SERFF Tracking Number:	*SNLF-126870003*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*48103*
Company Tracking Number:	*SLOC DENTAL 2010*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*Dental filing /*		

Filing at a Glance

Company: Sun Life Assurance Company of Canada

Product Name: Group Dental	SERFF Tr Num: SNLF-126870003	State: Arkansas
TOI: H10G Group Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num: 48103
Sub-TOI: H10G.000 Health - Dental	Co Tr Num: SLOC DENTAL 2010	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: James Crowley, Sandra Silcott, Marion Pagluica, Lori Chilcote, Pauline Michaud, Ellen Thibodeau, Linda Murphy, Frank Jancura, Stacy Amos	Disposition Date: 03/02/2011
	Date Submitted: 02/25/2011	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: Dental filing	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 12/14/2010
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 03/02/2011	
State Status Changed: 03/02/2011	Deemer Date:
Created By: Lori Chilcote	Submitted By: Lori Chilcote

Corresponding Filing Tracking Number:

Filing Description:

RE: SUN LIFE ASSURANCE COMPANY OF CANADA
NAIC #: 80802; FEIN: 38-1082080
See attached list of Group Dental Policy and Certificate Forms

Dear Commissioner:

SERFF Tracking Number:	*SNLF-126870003*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*48103*
Company Tracking Number:	*SLOC DENTAL 2010*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*Dental filing /*		

We are submitting the forms identified on the enclosed list for review and approval for use by Sun Life Assurance Company of Canada. These forms are new and not intended to replace any other forms currently in use.

The certificate and certificate amendment forms will be used with group policy forms GP-A-1 et al which were previously approved by your Department on August 16, 2008 under SERFF tracking number SNLF-25759955.

These forms are designed to provide group dental coverage in the following manner:

1. On a direct issue basis. The policy form will be issued in your state to groups recognized as eligible for group insurance in accordance with state insurance laws, rules and regulations, i.e. employer groups, union groups, trustee groups, etc.

2. On an out-of-state group trust basis. Coverage may be offered in your state to participating employers under a policy issued to a multiple employer trust situsedin Rhode Island. The trustee/policyholder for these funds is BankNewport, located at 747 Aquideneck Ave, Middletown, Rhode Island 02842.

Sun Life is entering into an agreement with a vendor to provide a dental network for its dental insurance products. The vendor agreement will afford Sun Life with an advantage over its competitors by achieving efficiencies, holding down costs, therefore allowing Sun Life to offer products in the marketplace at competitive rates. At this time, Sun Life considers the name of the provider network proprietary that has value and provides an advantage or an opportunity to obtain an advantage over those who do not know or use it. The company has taken measure to prevent the disclosure of the information to anyone other than those who have been selected to have access for limited purposes. The information is not currently publicly available elsewhere. As such, Sun Life asks that the name of the network not be made public.

Group Certificate Amendment GC-CA T10 has been developed to facilitate the rewriting of group dental insurance cases from Sun Life and Health Insurance Company (U.S.) (SLHIC) to Sun Life Assurance Company of Canada (SLOC). This form will provide that any representation made for the purposes of obtaining or continuing insurance under the SLHIC policy and any waiting period, deductibles and benefit maximums satisfied or partially satisfied under the SLHIC policy will be carried over to the new SLOC policy. This action has been necessitated by the sale of Genworth Financial's Employee Benefits Group business, including SLHIC (f/k/a Genworth Life and Health Insurance Company) to Sun Life Financial on May 31, 2007.

With regard to marketing information, this program will be offered on a contributory or non-contributory basis, where the insured may be required to contribute none, all, or a portion of the premium. Coverage will be marketed through agent/broker solicitation.

SERFF Tracking Number:	*SNLF-126870003*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*48103*
Company Tracking Number:	*SLOC DENTAL 2010*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*Dental filing /*		

The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts.
Any items intended to be variable are bracketed. An Explanation of Variable parameters is enclosed. As a point of information, variable data may vary from case to case. For example, the nature and structure of a group may require that certain terms be changed to fit the specific group. Amounts may vary or provisions may be modified to fit a specific policyholder's request. There may be other variations that may be changed as a result of negotiations between the policyholder and the Company. Please be assured that variable data will never exclude or limit provisions required by the jurisdiction in which the group policy is issued. With respect to mandated requirements, benefits greater than the mandates may be provided, where permitted.

Please refer to the supporting documentation tab for provider network materials along with an explanation of those attached documents

Attached to this filing are any applicable state required fees, transmittal forms, and certifications.

If you have any questions or comments regarding this submission, please do not hesitate to contact me at: (860) 737-1310, or by email at: James.Crowley@sunlife.com.

Company and Contact

Filing Contact Information

James Crowley, Compliance Consultant	James.Crowley@sunlife.com
175 Addison Road	800-451-2513 [Phone] 1310 [Ext]
P.O. Box 725	860-737-6598 [FAX]
Windsor, CT 06095-0725	

Filing Company Information

Sun Life Assurance Company of Canada	CoCode: 80802	State of Domicile: Michigan
175 Addison Road	Group Code: 549	Company Type:
Windsor, CT 06095	Group Name:	State ID Number:
(860) 737-1000 ext. [Phone]	FEIN Number: 38-1082080	

Filing Fees

Fee Required?	Yes
Fee Amount:	$750.00
Retaliatory?	No
Fee Explanation:	$50/form x 15 = $750.00

SERFF Tracking Number:	*SNLF-126870003*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*48103*
Company Tracking Number:	*SLOC DENTAL 2010*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*Dental filing /*		
Per Company:	No		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sun Life Assurance Company of Canada	$750.00	02/25/2011	45047515

SERFF Tracking Number:	*SNLF-126870003*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*48103*
Company Tracking Number:	*SLOC DENTAL 2010*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*Dental filing /*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/02/2011	03/02/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	03/01/2011	03/01/2011	Lori Chilcote	03/02/2011	03/02/2011

SERFF Tracking Number:	*SNLF-126870003*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*48103*
Company Tracking Number:	*SLOC DENTAL 2010*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*Dental filing /*		

Disposition

Disposition Date: 03/02/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SNLF-126870003*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*48103*
Company Tracking Number:	*SLOC DENTAL 2010*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*Dental filing /*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Explanation of Variables	Approved-Closed	Yes
Supporting Document	Forms List	Approved-Closed	Yes
Supporting Document	Provider Network Information	Approved-Closed	No
Form	Policy Form	Approved-Closed	Yes
Form *(revised)*	Certificate Form	Approved-Closed	Yes
Form	Certificate Form	Replaced	Yes
Form	Certificate Amendment Form	Approved-Closed	Yes
Form	Certificate Amendment Form	Approved-Closed	Yes
Form	Certificate Amendment Form	Approved-Closed	Yes
Form	Certificate Amendment Form	Approved-Closed	Yes

SERFF Tracking Number:	*SNLF-126870003*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*48103*
Company Tracking Number:	*SLOC DENTAL 2010*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*Dental filing /*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	03/01/2011
Submitted Date	03/01/2011
Respond By Date	

Dear James Crowley,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certificate Form, GC-A-1 (11) et al (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*SNLF-126870003*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*48103*
Company Tracking Number:	*SLOC DENTAL 2010*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*Dental filing /*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	03/02/2011
Submitted Date	03/02/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: Per your comment, we have revised the definition of “Handicapped Child” to remove the time limits for furnishing proof of incapacity. The definition now simply states that proof must be provided, with no time limitation.

Related Objection 1

Applies To:

- Certificate Form, GC-A-1 (11) et al (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Certificate Form	GC-A-1 (11) et al		Certificate	Initial		58.100	GC-A-1 (11) et al. (revised)pdf.pdf
Previous Version							
Certificate Form	*GC-A-1*		*Certificate*	*Initial*		*58.100*	GC-A-1

SERFF Tracking Number:	*SNLF-126870003*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*48103*
Company Tracking Number:	*SLOC DENTAL 2010*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*Dental filing / (11) et al*		(11) et al.pdf

No Rate/Rule Schedule items changed.

Sincerely,
Ellen Thibodeau, Frank Jancura, James Crowley, Linda Murphy, Lori Chilcote, Marion Pagluica, Pauline Michaud, Sandra Silcott, Stacy Amos

SERFF Tracking Number:	*SNLF-126870003*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*48103*
Company Tracking Number:	*SLOC DENTAL 2010*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*Dental filing /*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/02/2011	GP-A-5 (11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Policy Form	Initial		62.500	GP-A-5 (11).pdf
Approved-Closed 03/02/2011	GC-A-1 (11) et al	Certificate	Certificate Form	Initial		58.100	GC-A-1 (11) et al. (revised)pdf.pdf
Approved-Closed 03/02/2011	GC-CA TMD/CMD	Certificate Amendment, Insert Page, Endorsement or Rider	Certificate Amendment Form	Initial		58.900	GC-CA TMD-CMD.pdf
Approved-Closed 03/02/2011	GC-CA IMPLANT	Certificate Amendment, Insert Page, Endorsement or Rider	Certificate Amendment Form	Initial		63.700	GC-CA IMPLANT.pdf
Approved-Closed 03/02/2011	GC-CA NS-PERIO	Certificate Amendment, Insert Page, Endorsement or Rider	Certificate Amendment Form	Initial		54.600	GC-CA NS-PERIO.pdf

SERFF Tracking Number:	*SNLF-126870003*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*48103*
Company Tracking Number:	*SLOC DENTAL 2010*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*Dental filing /*		

Approved-Closed 03/02/2011	GC-CA T10 Certificate Amendment, Insert Page, Endorsement or Rider	Certificate Amendment Form	Initial		63.500	GC-CA T10.pdf

PREMIUMS

Computing [Employer] and [Employee] Premiums

Premiums for any insurance becoming effective for all of the [Policyholder's] [Employees] will be due from the effective date. Thereafter, all premiums will be due on the premium due dates.

Premium charges for insurance terminated as to all of the [Policyholder's] [Employees] will cease as of:

1. The termination date; or
2. The end of the grace period if insurance is in force for the grace period.

Charges for any insurance becoming effective or terminating for an individual [Employee], other than as stated above, will begin or end as of the first day of the month coinciding with or next following the effective date or termination date, as the case may be.

Instead of determining premiums as stated above, premiums may be determined by any method satisfactory to the Policyholder and us.

Changes in Computing the Premium

Instead of computing the premium on the rate basis shown below, we may use any method that we and the Policyholder agree to. We have the right to change the Initial Monthly Premium Rates below [[with respect to any or all employers]]:

1. as of any premium due date that occurs at least [6] months after the date of issue without consent of the Policyholder, any [[Employer,]] Employee, or any other person; or
2. if the policy is revised at the [Employer's] request or as mandated by state or federal legislation; or
3. at anytime the number of Employees insured under the policy on the Effective Date changes by more than 20%; or
4. at any time the number of Employees insured under the policy declines to less than [10].

We will provide written notification of any increases in the premium rate basis to the [Employer] at least 31 days prior to the effective date of the increase.

INITIAL MONTHLY PREMIUM RATES

The Initial Monthly Premium Rates [for ABC Employer] are as shown below:

[Dental Benefits	$00.00	Employee Only
	$00.00	Employee and Spouse
	$00.00	Employee, Spouse and Dependent Children]

PART 1: INSURANCE SCHEDULE

DENTAL EXPENSE BENEFITS
EMPLOYEE [[AND DEPENDENTS]]

Employee

EACH FULL-TIME NON-UNION EMPLOYEE

Date of Eligibility (Waiting Period):

90 DAYS

[[SCHEDULE OF DENTAL BENEFITS

Covered Expense	Per Person Deductible	Percentage of Covered Expenses Payable *	Per Person Maximum Benefit
Type I	$150.00 [[per Lifetime]] [[per Calendar Year]]	60%	Per Calendar Year: $500.00 for Type [I,] [II and] III expenses [combined].
[[Type II	$150.00 [[per Lifetime]] [[per Calendar Year]]	50%]]	
[[Type III	$150.00 [[per Lifetime]] [[per Calendar Year]]	30%]]	
[[Type IV	$150.00 [[per Lifetime]] [[per Calendar Year]]	30%	Type IV limited to: $500.00 per Lifetime]].

*After applicable Deductible.

[[Only one deductible applies per [[Calendar Year]] [[Lifetime]] if Type I, II, III, and IV Dental Expenses are Incurred.]]

[[The Maximum Family Deductible is $450.00.]]

If a Covered Person uses the services of a Participating Provider for Covered Dental Expenses, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the Maximum Allowable Charge. If a Covered Person uses the services of a Non-Participating Provider, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the provider's Usual charge.

[[Covered Expenses are determined by the Maximum Allowable Charge whether or not services are rendered by a Participating Provider.]] **]]**

[[SCHEDULE OF DENTAL BENEFITS

Covered Expense	Per Person Deductible	Percentage of Covered Expenses Payable* Network Expenses[[1]]	Non-Network Expenses[[2]]	Per Person Maximum Benefit
Type I	$150.00 [[per Lifetime]] [[per Calendar Year]] [for Non-Network Expenses only]	100%	100%	Per Calendar Year: $500.00 for Type [I,] [II and] III expenses [combined].
[[Type II	$150.00 [[per Lifetime]] [[per Calendar Year]]	90%	80%	
[[Type III	$150.00 [[per Lifetime]] [[per Calendar Year]]	60%	50%	
[[Type IV	$150.00 [[per Lifetime]] [[per Calendar Year]]	60%	50%	Type IV limited to $500.00 Per Lifetime

*After applicable Deductible.

[[Only one deductible applies per [[Calendar Year]] [[Lifetime]] if Type I, II, III, and IV dental expenses are Incurred. The deductible is waived for Type I Network Expenses.]]

[[The Maximum Family Deductible is $450.00.]]

[1 Benefits based on Maximum Allowable Charge.]

[2 Benefits based on Usual and Customary Charges.]

[[If a Covered Person uses the services of a Participating Provider for Covered Dental Expenses, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the Maximum Allowable Charge. If a Covered Person uses the services of a Non-Participating Provider, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the provider's Usual charge.]]

[[Covered Expenses are determined by the Maximum Allowable Charge whether or not services are rendered by a Participating Provider.]] **]]**

[[SCHEDULE OF DENTAL BENEFITS
NETWORK EXPENSES[1]

Covered Expense	Per Person Deductible	Percentage of Covered Expenses Payable*	Per Person Maximum Benefit
Type I	$150.00	60%	Per Calendar Year: $500.00 for Type [I,] [II and] III expenses [combined].
[[Type II	$150.00	50%]]	
[[Type III	$150.00	30%]]	
[[Type IV	$150.00	30%	Per Lifetime: $500.00 for Type IV]].

NON-NETWORK EXPENSES[2]

Covered Expense	Per Person Deductible	Percentage of Covered Expenses Payable*	Per Person Maximum Benefit
Type I	$300.00	40%	Per Calendar Year: $250.00 for Type [I,] [II and] III expenses [combined].
[[Type II	$300.00	30%]]	
[[Type III	$300.00	20%]]	
[[Type IV	$300.00	20%	Per Lifetime: $250.00 for Type IV]]

*After applicable Deductible.

Only one deductible applies if Type I, II , III and IV expenses are Incurred. The deductible is waived for Type I Network Expenses.

[[The Maximum Family Deductible for Network Expenses is $300.00 and for Non-Network Expenses is $900.00.]]

The Per Person Maximum Benefit for Network and Non-Network Expenses combined is:

a) $500.00 per Calendar Year for Type I, II and III expenses [combined]; and

b) $500.00 per Lifetime for Type IV expenses.

[1 Benefits based on Maximum Allowable Charge.]

[2 Benefits based on Usual and Customary Charges].

If a Covered Person uses the services of a Participating Provider for Covered Dental Expenses, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the Maximum Allowable Charge. If a Covered Person uses the services of a Non-Participating Provider, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the provider's Usual Charge.]

[[Covered Expenses are determined by the Maximum Allowable Charge whether or not services are rendered by a Participating Provider.]] **]]**

PART 2: DEFINITIONS

[Accidental Bodily Injury

A bodily injury resulting directly from an accident, and independently of all other causes.

Actively At Work

You are actively at work on any day if on that day you are:

1. Working at your Employer's usual place of business or at such place or places that the Employer's normal course of business may require;
2. Performing all of the duties of your job on a full-time basis; and
3. Not confined in any institution providing care or treatment of physical or mental infirmities.

[[Open Enrollment Period

A specified period each year, determined by the Employer, when you may elect to purchase or cancel your Dental Insurance [or elect to become covered under an alternate plan of Dental Expense Benefits made available by the Employer and provided by us.]]]

[Calendar Year

[The period beginning on [January 1st] and ending on [December 31st] of the [same] year.]

[Benefit Year

A 12 month period determined by your Employer during which plan features such as deductibles and maximums accumulate and during which plan limitations may apply.]

[[Child

The term "Child":

1. Means a child who:
   - [a) is unmarried;
   - b) is receiving more than 50% of support from you; or has been recognized as having the right to benefits under This Plan under a qualified medical child support order or other similar court decree; and
   - c) is either:
     - i) under 19 years of age; or
     - [[ii) a Full-time Student and under 25 years of age; or]]
     - iii) a Handicapped Child as defined below; and
2. Is limited to:
   - a) your natural born child or other child related to you by blood;
   - b) your stepchild;
   - c) your foster child;
   - d) your legally adopted child or child placed with you pending adoption; and]
   - [[e) the child of your Domestic Partner;]] [and
3. Is subject to this restriction: No Child will be considered as a Dependent of more than one insured Employee.] **]]**

Covered Person

You [or your Dependent] who is insured for Dental Expense Benefits.

Customary Charge

A fee level selected by your Employer based on the amount standardly charged by most dental offices in the locality where the charge for a service is Incurred. Locality means an area whose size is large enough, as determined by us, to give an accurate representation of standard charges for that type of service. **]**

[Dental Prophylaxis

Preventive treatment which includes scaling and polishing, the complete removal of explorer-detectable calculus, soft deposits, plaque, stains and the smoothing of tooth surfaces coronal to the gingival attachment. [[For benefit purposes, periodontal maintenance shall be considered as an adult prophylaxis.]] A multiple appointment cleaning shall be considered as a single prophylaxis.

Dental Treatment Plan

The Dentist's report of recommended treatment on a form satisfactory to us which:

1. Itemizes the dental procedures and charges required for the necessary care of the mouth;
2. Lists the Usual Charges for each procedure; and
3 Is accompanied by supporting x-rays and any other appropriate diagnostic materials as required by us.

Dentist

Someone who meets both of the following requirements:

1. Is currently licensed to practice dentistry by the state in which he or she practices; and
2. Is acting within the scope of his or her license. **]**

[[Dependent

The term "Dependent":

1. Means:
   a) your lawful spouse [[or Domestic Partner]]; or
   b) your Child; but
2. Does not include a person who:[[
   a) is an Employee of your Employer unless you and your spouse [[or Domestic Partner]] are each Employees of your Employer and you have or acquire a Dependent Child. In that event, the Employee whose employment date with your Employer is the later of the two will be insured as a Dependent rather than an Employee, subject to the "Date of Eligibility" section under DEPENDENT COVERAGE and all the other terms of the policy; or
   b)]] resides outside the United States. A Dependent Child who is attending school outside the United States will be deemed to be residing within the United States. A Dependent Child residing outside the United States but not attending school will not be insured as a Dependent unless approved by us in writing.]]

[[Domestic Partner

Domestic Partner means your domestic partner as defined by your Employer and/or state law.]]

[Eligible Employee

Someone who under the terms of the policy:

1. Meets the requirements in the definition of Employee; and
2. Completes the waiting period (described in the "Date of Eligibility" section); [[and
3. Is working within the United States. An employee who is working on a temporary assignment outside the United States for a period of 12 months or less will be deemed to be working within the United States. An employee working outside the United States on other than a temporary assignment will not be considered an Eligible Employee unless approved by us in writing.]]

[[If your earnings from the Employer are reported to the Internal Revenue Service on Form 1099 or other form designated by the Internal Revenue Service to report payments to an independent contractor rather than payments to an employee, you will not be considered to be an Eligible Employee unless approved by us in writing.]]

Employee

Someone who meets the following requirements:

1. Is an employee of the Employer, as stated in PART 1: Insurance Schedule;
2. Regularly works at the Employer's usual place of business or at such place or places that the Employer's normal course of business may require;
3. Regularly works the number of hours required by the Employer to be eligible for insurance;
4. Is paid for such work in accordance with applicable Wage and Hour Laws; and
5. Is in a classification eligible for insurance as noted in the Insurance Schedule.

Employer (Eligible Employer)

The Policyholder shown on the first page.**]**

[[Full-time Student

A Child who:

1. Is attending on a full-time basis a college or university licensed as such by the state in which it is located; and
2. Is enrolled for at least the minimum number of course credits required by such college or university to maintain standing as a full-time student.]]

[[Handicapped Child

A Handicapped Child is a Child who may be insured beyond the applicable age limit shown in the definition of Child, as long as:

1. Such a Child is:
   a) unmarried;
   b) incapable of self-sustaining employment by reason of:
      i) mental retardation; or
      ii) physical handicap;
   c) dependent upon you for support and maintenance; and
   d) insured:
      i) under the policy upon attaining age 19; [[or
      ii) under the policy prior to or upon attaining age 25, if such Child is a Full-time Student;]] or
      iii) as a handicapped child under a group dental insurance plan of your Employer immediately prior to the date on which your Employer became an Eligible Employer; and

2. You submit on the Child's behalf Proof of such incapacity and dependency.]]

[Incurred (Incurred Date)

Charges for COVERED DENTAL EXPENSES will be considered incurred as follows:
Charges for multivisit procedures are considered incurred when the treatment is completed. Charges for all other services are incurred on the date that the service is provided. If This Plan includes coverage for Type IV Orthodontic Services, charges for those services are considered incurred on the date of insertion of the bands or appliance.

Late Entrant

Late Entrant means someone who:

1. Complies with the "Conditions of Insurability" for Dental Expense Benefits more than 31 days after he or she becomes eligible; or
2. Requests reinstatement of insurance which was terminated while he or she remained eligible for insurance under the policy.

Maximum Allowable Charge

The pre-determined fee (that has been agreed to [[by us or]] by an organization with whom we have contracted and the Participating Provider) charged and received for a given service by the Dentist's office in the area where the charge for such service is made.

[[Network Expenses

Covered Dental Expenses for services that are furnished by a Participating Provider.]]

[[Non-Network Expenses

Covered Dental Expenses for services that are furnished by a Non-Participating Provider.]]

Non-Participating Provider

Any Dentist who has not entered into a service agreement with [[us or with]] an organization with whom we have contracted to provide dental services at the pre-determined Maximum Allowable Charge.]

[[Orthodontic Treatment

Means the corrective movement of teeth through bone by means of an active appliance to correct a malocclusion.]]

[Participating Provider

Any Dentist who has entered into a service agreement with [[us or with]] an organization with whom we have contracted to provide dental services at the pre-determined Maximum Allowable Charge.

Proof

Any information that is:

1. Required by us under the terms of the policy; and
2. Satisfactory to us.

Qualified Status Change

A Qualified Status Change means:

1. Birth or adoption of a child;
2. Marriage [[or addition of a Domestic Partner]];
3. Involuntary loss of other dental coverage.

[[Retired Employee

An Eligible Employee whose employment with the Employer has ended or ends due to retirement.]]

This Plan

Your Employer’s plan of DENTAL EXPENSE BENEFITS with us as described in this Certificate and any attached Certificate Amendment(s).

Usual Charge

The fee regularly charged and received for a given service by the Dentist's office.

We (we, us, Our, our)

Sun Life Assurance Company of Canada

You (you, Your, your)

The Employee.]

PART 3: DENTAL EXPENSE BENEFITS: EMPLOYEE INSURANCE

[Date of Eligibility (Waiting Period)

You will be eligible for insurance on the date you complete the number of consecutive days or months of [[full-time]] continuous active service shown in the Insurance Schedule.

If you elect to be covered under an alternate plan of dental benefits made available by your Employer, you will not be eligible for these Dental Expense Benefits.

Conditions of Insurability

To become insured under the policy you must:

1. Satisfy the Waiting Period shown in the Insurance Schedule;
2. Complete and submit one of our enrollment forms or, if applicable, one of the enrollment forms that we and your Employer have agreed to use in place of our enrollment forms; and
3. Agree to make any required contribution toward the cost of the insurance.

[[[If you submit an enrollment form more than 31 days after the date you become an Eligible Employee or after the date of a Qualified Status Change, you cannot enroll until the next Open Enrollment Period.] [you are a Late Entrant with respect to Employee Insurance and you will be subject to the "Limitation on Late Entrants" section below.]]]

Effective Date of Insurance

Once you have met the Conditions of Insurability, you will be insured under the policy on the date you become eligible.

[If you enroll during the Open Enrollment Period, you will be insured under the policy on the date determined by your Employer.]

[[Voluntary Disenrollment

If you choose to cancel your coverage under This Plan at any time [during the Calendar Year other than during the Open Enrollment Period][during the Open Enrollment Period}, you will not be permitted to re-enroll at a later time unless you supply proof of involuntary loss of coverage under another group dental plan. The loss of coverage must be due to a valid life change event such as death, divorce or change in employment status of your spouse. If you supply such proof, you will be permitted to re-enroll [at the next Open Enrollment Period]]]

[[Benefit Waiting Period[s]

You will be insured for Type I Dental Expenses on your Effective Date of Insurance. There [is a] Benefit Waiting Period[s] for [Type II, [[and]] Type III and Type IV] Dental Expenses as indicated below. The Benefit Waiting Period(s) begin(s) on your Effective Date.

[1. The Benefit Waiting Period for Type II Dental Expenses is [6] months.]

[2. The Benefit Waiting Period for Type III Dental Expenses is [12] months.]

[3. The Benefit Waiting Period for Type IV Dental Expenses is [24] months.]

Once you have satisfied the applicable Benefit Waiting Period, your coverage for that expense type will be effective on the [first of the month coinciding with or next following the] date you have satisfied that waiting period.

[[The Benefit Waiting Period[s] shown above will not be applied if you were enrolled in the Employer's group dental plan that was in force on the day before the effective date of This Plan.]]]]

[[Limitation on Late Entrants

For the first 24 months that a Late Entrant is insured for these DENTAL EXPENSE BENEFITS, the benefits will be limited to the benefits shown in items 1 and 2 below:

1. Benefits for the first 12 months will be limited to Type I COVERED DENTAL EXPENSES.
2. Benefits for the second 12 months will be limited to Type I and Type II COVERED DENTAL EXPENSES

If you request reinstatement of insurance that was terminated while you remained eligible for such insurance under the policy, the above limitations will apply from the date on which such insurance is reinstated. Any time period for which such insurance was effective prior to such date cannot be used to satisfy the time limitations stated above.]]]

[[PART 3A: DENTAL EXPENSE BENEFITS: DEPENDENT COVERAGE

Date of Eligibility

If you have at least one Dependent on the date you become insured for Employee Insurance, you will become eligible for Dependent Coverage on that date. If you do not have a Dependent on that date, you will become eligible for Dependent Coverage on the date that you acquire one. [[If you and your spouse [[or Domestic Partner]] are both insured as Employees of your Employer on the date you acquire a Dependent Child, then on such date, the Employee whose employment date with the Employer is the later of the two will be deemed a Dependent rather than an Employee, subject to all the terms of the policy.]]

Conditions of Insurability

To become insured with respect to a Dependent:

1. You must satisfy the Waiting Period shown in the Insurance Schedule;
2. You must be insured for Employee Insurance;
3. Your Employer must notify us that you have or have acquired such Dependent;
4. You must agree in writing to make any required contribution.
5. If any of the requirements in items 3, or 4, of this section are met more than 31 days from the date:
   a) you become eligible for coverage for a Dependent;
   b) your Child reaches age 3; or
   c) of a Qualifying Status Change, then

   you cannot enroll that Dependent until the next Open Enrollment Period.

Effective Date of Insurance

Once you have met the Conditions of Insurability, you will be insured, with respect to your Dependent[[:

1.]] on the date you become eligible for Dependent Coverage.[[or

2. If you enroll your Dependent during the Open Enrollment Period, on the date determined by your Employer.]]

[[Voluntary Disenrollment

If you choose to cancel your Dependent Coverage at any time [during the Calendar Year other than during the Open Enrollment Period][during the Open Enrollment Period}, you will not be permitted to re-enroll for Dependent Coverage at a later time unless you supply proof of involuntary loss of coverage under another group dental plan. The loss of coverage must be due to a valid life change event such as death, divorce or change in employment status of your spouse. If you supply such proof, you will be permitted to re-enroll [at the next Open Enrollment Period]]]

[[Benefit Waiting Period[s]

You will be insured for Type I Dental Expenses on the Effective Date of your Dependent Coverage. There [is a] Benefit Waiting Period[s] for [Type II, [[and]] Type III and Type IV] Dental Expenses as indicated below. Benefit Waiting Period(s) begin on your Effective Date.

[1. The Benefit Waiting Period for Type II Dental Expenses is [6] months.]

[2. The Benefit Waiting Period for Type III Dental Expenses is [12] months.]

[3. The Benefit Waiting Period for Type IV Dental Expenses is [24] months.]

If you are insured for Dependent Coverage and you have satisfied the applicable Benefit Waiting Period, your Dependent Coverage for that expense type will be effective on the [first of the month coinciding with or next following the] date you have satisfied that waiting period.

[[The Benefit Waiting Period[s] shown above will not be applied if you were enrolled in the Employer's group dental plan that was in force on the day before the effective date of This Plan.]]]]

[[Limitation on Late Entrants

If you are a Late Entrant, benefits for the first 24 months of coverage for your Dependent will be limited to the benefits shown in items 1 and 2 below :

1. Benefits for the first 12 months will be limited to Type I COVERED DENTAL EXPENSES.
2. Benefits for the second 12 months will be limited to Type I and Type II COVERED DENTAL EXPENSES.**]]**

PART 4: DENTAL EXPENSE BENEFITS: DETERMINATION OF BENEFITS

[Pre-Determination of Benefits

Pre-Determination of Benefits is recommended for extensive treatment such as root canal therapy, crowns, bridges and periodontal treatment, if such services are included under This Plan. We recommend that the DENTAL TREATMENT PLAN be submitted to us for review before treatment begins. We will notify you and the Dentist of the benefits payable based upon the DENTAL TREATMENT PLAN. In determining the amount of benefits payable, consideration will be given to Alternate Dental Treatment that will, as determined by us, accomplish a professionally satisfactory result. If you and the Dentist agree to a more costly method of treatment, than that determined by us, the excess amount will not be paid by us. Pre-determination of Benefits is not required and failure to submit a Pre-Determination of Benefits does not affect the amount of benefits payable by us.

Conditions Under Which Benefits Are Payable

We will pay benefits as described below subject to the following:

1. Our payment of benefits described below is subject to all the terms and conditions of the policy;
2. We will not pay benefits for any one item of expense under more than one provision of the policy. All related dental expenses will be considered as part of the most comprehensive procedure and only the benefit for such procedure will be payable; and
3. The maximum amount that we will pay for[[:
   a)]] Type [[I,]] [[Type II and]] Type III COVERED DENTAL EXPENSES [[combined]] is described in the "Calendar Year Maximum Benefit" section below;[[and
   b) Type IV COVERED DENTAL EXPENSES is described in the "Lifetime Maximum Benefit" section below.]]

Benefits Payable with respect to Type I, [Type II] [and Type III] COVERED DENTAL EXPENSES

If during a Calendar Year a Covered Person Incurs COVERED DENTAL EXPENSES in excess of the Deductible, we will pay to you a benefit equal to the applicable percentage shown in the Insurance Schedule of Type I, [Type II] [and/or Type III] COVERED DENTAL EXPENSES Incurred in excess of the applicable Deductible, subject to the Calendar Year Maximum Benefit.]

[[Benefits Payable For Type IV COVERED DENTAL EXPENSES

Upon receipt of Proof of claim that any Covered Person has Incurred Type IV COVERED DENTAL EXPENSES, the benefit payable will be:

1. Equal to the percentage shown in the Insurance Schedule for Type IV COVERED DENTAL EXPENSES; and
2. Limited to the Lifetime Maximum Benefit.]]

[Deductible

[[Any Per Person Deductible per [[Calendar Year]] [[Lifetime]] for each type of COVERED DENTAL EXPENSE is shown in the Insurance Schedule. The amounts to be applied to meet the Deductible must be charges for COVERED DENTAL EXPENSES.

Amounts applied for your family will not exceed the Maximum Family Deductible shown in the Insurance Schedule in any Calendar Year, even if the Per Person Deductible has not been met.]]

[[The Per Person Deductible amounts for Network and Non-Network Expenses per Calendar Year for each type of COVERED DENTAL EXPENSE are shown in the Insurance Schedule. When Covered Dental Expenses are Incurred, the applicable deductible (Network or Non-Network) must be met before any benefits are payable for those expenses. Covered Dental Expenses Incurred toward the satisfaction of one of these deductibles (Network or Non-Network) in a Calendar Year will be applied toward the satisfaction of the other deductible (Network or Non-Network) for that year. The maximum Per Person Deductible for a Calendar Year will not exceed the Per Person Deductible amount for Non-Network Expenses shown in the Insurance Schedule.

Amounts applied for your family in any Calendar Year will not exceed the Maximum Family Deductibles for Network and Non-Network Expenses that are shown in the Insurance Schedule, even if the Per Person Deductible has not been met.]]

Calendar Year Maximum Benefit

[[The Per Person Maximum Benefit in each Calendar Year for [Type I, Type II and Type III] expenses [[combined]] is shown in the Insurance Schedule. The Calendar Year Maximum Benefit applies to all periods of time the Covered Person is insured during a Calendar Year regardless of any interruption in coverage for this insurance.

This Maximum Benefit applies to all COVERED DENTAL EXPENSES whether they are Network or Non-Network Expenses.]]

[[The Per Person Maximum Benefit amounts for Network and Non-Network Expenses in each Calendar Year for Type I, Type II and Type III expenses combined are shown in the Insurance Schedule.

Only Network Expenses will be applied toward the Per Person Maximum Benefit for Network Expenses. Only Non-Network Expenses will be applied toward the Per Person Maximum Benefit for Non-Network Expenses.

The Per Person Maximum Benefit for Network and Non-Network Expenses combined is shown in the Insurance Schedule.]]

The Maximum Benefit applies to all periods of time the Covered Person is insured during a Calendar Year regardless of any interruptions in coverage for this insurance. **]**

[[Lifetime Maximum Benefit

[[The Lifetime Maximum Benefit payable for any Covered Person who Incurs Type IV expenses is shown in the Insurance Schedule. The Lifetime Maximum Benefit applies to all periods of time the Covered Person is insured for DENTAL EXPENSE BENEFITS under the policy regardless of any interruptions in coverage for this insurance.]]

[[The Per Person Lifetime Maximum Benefit amounts for Network and Non-Network Type IV expenses are shown in the Insurance Schedule. Only Network Expenses will be applied toward the Per Person Lifetime Maximum Benefit for Network Expenses. Only Non-Network Expenses will be applied toward the Per Person Lifetime Maximum Benefit for Non-Network Expenses. The Per Person Lifetime Maximum Benefit for Network and Non-Network Expenses combined is shown in the Insurance Schedule. The Lifetime Maximum Benefit applies to all periods of time the Covered Person is insured for DENTAL EXPENSE BENEFITS under the policy regardless of any interruptions in coverage for this insurance.]]

This Maximum Benefit applies to all Type IV COVERED DENTAL EXPENSES whether they are Network or Non-Network Expenses.]]

[Alternate Dental Treatment

If we determine that alternate procedures, services or courses of treatment can be performed to correct a dental condition, payment will be considered for the least costly procedure which we determine will produce a professionally satisfactory result.

Favorable Result of Treatment

Benefits will be considered only for treatment that we determine has a reasonably favorable prognosis.]

[Benefits After Termination of Insurance

No benefits are available after a Covered Person's insurance ends with the exception of the following:

Benefits are available for procedures requiring multiple visits if the treatment is started while a Covered Person is insured and completed within 90 days after the Covered Person's insurance ends. Treatment is considered started when the tooth is irrevocably altered. This extension is limited to crowns, fixed bridges, inlays, onlays, full dentures, partial dentures and root canal therapy if such services are included under This Plan. A pre-determination for any Dental Treatment Plan does not constitute treatment started. If Orthodontic Treatment is included in This Plan, benefits for Type IV Expenses will be continued through the last day of the calendar month in which coverage terminates.]

PART 5: DENTAL EXPENSE BENEFITS: COVERED DENTAL EXPENSES

A COVERED DENTAL EXPENSE is:

1. With respect to services rendered by a Participating Provider, the lesser of the Usual Charge or the Maximum Allowable Charge;
2. With respect to services rendered by a Non- Participating Provider, the lesser of the Usual Charge or the Customary Charge [[or the Maximum Allowable Charge]]

for any of the dental services listed below, when those services are performed by a Dentist and are essential, as determined by us, for the necessary dental care of a Covered Person, and which have a favorable prognosis, as determined by us.

The following is a list of those dental services which will be considered as COVERED DENTAL EXPENSES; expenses that are Incurred for the performance of any dental service not listed below will be considered a COVERED DENTAL EXPENSE only if we agree in writing to accept such expenses as COVERED DENTAL EXPENSES. If we so agree, the benefit that we pay will be consistent, as determined by us, with a payment for such similar COVERED DENTAL EXPENSES that would provide the least costly professionally adequate treatment.

Type I Dental Services

Service	Special Limitations
[Oral Evaluations: Comprehensive and Periodic	Limited to 2 of these services in any 12 consecutive month period. Comprehensive evaluations are limited to one time per dental office unless there is a significant change in dental health or if the patient is absent from the office for 3 or more years
Oral Evaluations: Consultations and Limited Problem focused	Limited to 1 of these services per dentist per patient in any 12 [consecutive month] period.
Oral Evaluation: Detailed Problem focused	Limited to 1 time per dentist per eligible diagnosis in any 12 [consecutive month] period.
[[Bite-Wing X-rays	Limited to 1 set in any 12 [consecutive month] period [[for Covered Persons under age 14 and 1 set in any 24 consecutive month period for Covered Persons age 14 and older.]]]]
Dental Prophylaxis	Limited to 2 times in any 12 [consecutive month] period; 1 additional for a Covered Person under the care of a medical professional for pregnancy.
Fluoride Treatments	Limited to 2 times in any 12 [consecutive month] period and to Covered Persons under the age of 19.
Space Maintainers	Limited to 1 in any [3 year] period for Covered Persons under the age of 19 when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not develop.
Sealants	Limited to 1 time per tooth in any 36 [consecutive month] period. Limited to permanent first and second molars and to Covered Persons under age 16.
Palliative Treatment]	

[Type II Dental Services

[[You will not be eligible for Type II COVERED DENTAL EXPENSES until [the first day of the month coinciding with or next following the date] you have been insured under the policy for at least 12 consecutive months. [[This Benefit Waiting Period will not be applied if you were enrolled in the Employer's group dental plan that was in force on the day before the effective date of This Plan.]]]]

Service	Special Limitations
[Simple Extraction	
Full Mouth X-rays	Limited to 1 in any [60 consecutive month period].
[All other X-rays]	
Amalgam Restorations	Limited to 1 time per tooth surface in any 12 consecutive month period. Restorations involving multiple surfaces will be combined for benefit purposes and paid according to the number of discrete surfaces treated.
Composite Restorations	Limited to 1 time per tooth surface in any 12 consecutive month period. [Restorations on posterior teeth will be paid as an amalgam restoration].
Stainless Steel Crowns	Limited to 1 time per tooth per lifetime and to Covered Persons under age 15.
Re-cement Cast Post, Inlays, Crowns, Bridges	Considered part of the charge for the cast post, inlay, crown or bridge if the recementation is done by the same dentist and is within 12 consecutive months of the crown or bridge insertion. Subsequent recementations are limited to [one in any 12 consecutive month] period.
Repairs to Full Dentures, Partial Dentures, Bridges	
Hemisection	
Pulpal Therapy	Limited to 1 time per eligible tooth per lifetime. [Eligible teeth are primary anterior teeth for Covered Persons under age 6 and primary posterior molars for Covered Persons who are under age 12].
Root Canal Therapy	Limited to 1 time per tooth per lifetime.
Root Canal Retreatment	Limited to 1 time per tooth per lifetime.]

[Apicoectomy and Retrograde Filling	
Scaling and Root Planing	Limited to 1 time per quadrant of the mouth in any 24 [consecutive month] period.
Periodontal Maintenance following active periodontal therapy	Limited to 1 time in any 6 [consecutive month] period in addition to routine dental prophylaxis.
Surgical periodontal procedures	Once per area of the mouth in any 24 [consecutive month] period.
Guided tissue regeneration	Limited to 1 time per tooth per lifetime.
Full mouth debridement	Limited to 1 time per tooth per lifetime.
[[Biopsy]]	
Alveoplasty	
Incision and Drainage	
[[Removal of a Cyst	Not payable in addition to extraction performed in the same site on the same date.]]
Surgical Extraction of Erupted Teeth and Impacted Teeth	
General Anesthesia[,Nitrous Oxide] [IV Sedation]]	

[Type III Dental Services

[[You will not be eligible for Type III COVERED DENTAL EXPENSES until [the first day of the month coinciding with or next following the date] you have been insured under the policy for at least 12 consecutive months. [[This Benefit Waiting Period will not be applied if you were enrolled in the Employer's group dental plan that was in force on the day before the effective date of This Plan.]]]]

Service	Special Limitations
Inlays and Onlays	Covered only when the tooth cannot be restored by a filling or by other means. Limited to 1 per tooth in any 5 [Calendar Years.]
[[Porcelain Restorations	Covered only if the tooth cannot be restored by a filling or by other means.]]
Crown Buildup or Core Buildup	Limited to 1 per tooth in any 5 [Calendar Years.]
Crowns	Covered only if the tooth cannot be restored by a filling or by other means. Limited to 1 per tooth in any 5 [Calendar Years.]
Cast Post and Core	Limited to 1 per tooth in any 5 [Calendar Years].
Full or Partial Dentures	[See item 32 of EXCLUSIONS.] Limited to 1 in any 5 [Calendar Years].
Relining Dentures, Rebasing Dentures or Denture Adjustments	Considered part of the denture charges if services are provided by the same dentist and are within 6 months of insertion. Subsequent relining or rebasing is limited to 1 time in any 36 [consecutive month] period.
Fixed Bridges	[See item 32 of EXCLUSIONS.] Limited to 1 in any 5 [Calendar Years].
Root Recovery	
Frenectomy]	

[[Type IV Orthodontic Dental Services

[[You will not be eligible for Type IV COVERED DENTAL EXPENSES until [the first day of the month coinciding with or next following the date] you have been insured under the policy for at least 24 consecutive months. [[This Benefit Waiting Period will not be applied if you were enrolled in the Employer's group dental plan that was in force on the day before the effective date of This Plan.]]]]

Service	Special Limitations
Cephalometric X-ray	
Orthodontic Treatment	
Study Models]]	

PART 6: DENTAL EXPENSE BENEFITS: EXCLUSIONS

[COVERED DENTAL EXPENSES do not include and no benefits are provided for:

1. Procedures which are not included in the list of COVERED DENTAL EXPENSES.
2. Procedures which are elective. (e.g. the prophylactic extraction of third molars).
3. Procedures related to the change of vertical dimension, restoration of occlusion, bite registration, or bite analysis.
4. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
5. Implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants.
6 Specialized procedures and techniques (e.g. precision or semi-precision attachments, copings, over dentures or customized prostheses or attachments.)
7. Duplicate dentures, prosthetic devices or any other duplicative device.
8. Procedures that we determine are cosmetic in nature.
9. Charges for any of the following:
   a) dental care resulting from any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of an country or international authority;
   b) dental care resulting from any injury which is self-inflicted or not caused by an accident;
   c) dental care resulting from active participation in a riot;

      The words "participation" and "riot" in the phrase "participation in a riot" will be defined as follows:

      Participation - includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but will not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

      Riot - includes all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together whether or not acting with common intent and whether or not damage to person or property or unlawful act or acts is the intent or the consequences of such disorder; and
   d) dental care resulting from participation in the commission of a felony.
10. Dental care arising out of or in the course of employment for pay or profit or which is covered by Workers' Compensation or a similar law, or for which the Covered Person is entitled to payment under an automobile insurance policy. Benefits paid by us would be in excess to the third-party benefits and therefore, we would have the right of recovery for any benefits paid in excess.
11. Charges for pulp caps.
12. Charges for failure to keep appointments.
13. Charges for diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are temporomandibular joint disorders or other conditions of the joint linking the jaw bone and the complex muscles, nerves and other tissues related to the joint.
14. COVERED DENTAL EXPENSES Incurred while insurance is not in force under This Plan.
15. Charges for care, treatment, services, or supplies to the extent that any benefit is provided by Medicare.
16. Charges which are not customarily made when there is no insurance, or charges for which there is no legal obligation to pay.
17. Dental care which is not customarily performed or which is Experimental in nature. . By Experimental, we mean: The use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which we determine is not acceptable standard dental treatment of the condition being treated. Any such items requiring federal or other governmental agency approval which was not granted at the time the services were rendered will also be considered Experimental. In making the determination as to whether dental care is Experimental, we will rely on the advice of the general dental community including, but not limited to dental consultants and dental journals and/or regulations.]

[18. Charges for oral hygiene instruction, a plaque control program, tobacco counseling or dietary instruction.

19. Charges for treatment started prior to a Covered Person's Effective Date. Multivisit procedures are considered started when the teeth are irrevocably altered. For example, crowns, bridges and dentures are considered started when the teeth are prepared and impressions are taken. Root canals are considered started when the tooth is open and pulp is removed.

20. Charges for house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).

21. Charges for diagnostic casts.

22. Charges for periodontal splinting of teeth by any method.

23. Charges for prescription and non-prescription drugs, vitamins or dietary supplements.

24. Charges for treatment of fractures and dislocations of the jaw.

25. Charges for treatment of malignancies or neoplasms.

26. Charges for preventive restorations.

27. Charges for any treatment of congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone or required as the result of orthognathic surgery including orthodontic treatment).

28. Charges for treatment of and appliances for bruxism (night grinding of teeth).

29. Charges for incomplete treatment (e.g. patient does not return to complete treatment) and charges for temporary services (e.g. temporary restorations.

30. Charges for procedures that are:

    a) part of a service but are reported as separate services;

    b) reported in a treatment sequence that is not appropriate;

    c) misreported or that represent a procedure other than the one reported.

31. [[Orthodontic Treatment]] [[for Covered Persons age 19 and older.]]

[[32. The initial placement of prosthetics (e.g. full or partial dentures or fixed bridges) if the prosthetic replaces one or more teeth missing prior to the Covered Person's effective date of coverage, including congenitally missing teeth.]] [[This exclusion will not be applied if you were enrolled in the Employer's group dental plan that was in force on the day before the effective date of This Plan]].

[[33. Charges for the administration of [nitrous oxide and/or] IV sedation.]]

[[34. Charges for treatment that is not dentally necessary or not deemed to be within generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the determination will be made by us.]]]

PART 8: TERMINATION PROVISIONS

[Termination of Employee [[and Dependent]] Insurance

The DENTAL EXPENSE BENEFITS coverage for you [[and your Dependents]] will automatically cease on the earliest date shown below:

[[1. On the date you are no longer Actively At Work except that:

a) while you are sick or injured, your employment will be deemed to continue, for up to 12 months from the date your disability began as long as your Employer keeps paying premiums on your behalf;

b) while you are temporarily laid off or on a temporary leave of absence, your employment will be deemed to continue, as long as premium payments are made, for up to two months, unless your Employer cancels your insurance before the end of that time;

c) while you are on an approved leave of absence granted in accordance with a State Family Leave Law or the Federal Family and Medical Leave Act (FMLA), your coverage will be deemed to continue, provided premium payments are made and the continuation of coverage during this leave is based upon a uniform policy of your Employer and not individual selection, for the lesser of the duration of the approved leave or 4 months from the last day you are Actively At Work, unless your Employer cancels your insurance before the end of that time;

d) while you are on a leave of absence due to your military service in any of the Uniformed Services of the United States, your employment will be deemed to continue as outlined in either item 1-b or 1-c above, as applicable, as long as premium payments are made, unless your Employer cancels your insurance before the end of that time. For additional information on how you can continue your coverage, see the **Uniformed Services Employment and Re-employment Rights Act of 1994** part.

[[e) when you become a Retired Employee, your Dental Expense Benefits coverage will be deemed to continue as long as your Employer keeps paying premiums on your behalf;]]]]

2. On the date which you cease to be in a class of Employees who are eligible for such coverage. This means you are no longer an active [[full-time]] Employee;
3. On the date you fail to make any required contribution;
4. On the date such coverage is terminated for any reason;
5. On the date such coverage is terminated for the class of Employees to which you belong;

[[6. On the date the policy terminates.]]

[[6. On the date your Employer's participation in the Trust and under the policy is terminated.]]

7. On the date you become covered under an alternate plan of dental benefits made available by your Employer.

[[Termination of Dependent Coverage Only

The DENTAL EXPENSE BENEFITS coverage for your Dependents only will automatically cease before your Employee Insurance on the earliest of:

1. The date you cease to be in a class of Employees who are eligible for such Dependent Coverage;
2. The date you fail to make any required contribution for such Dependent Coverage;
3. The date such Dependent Coverage is terminated for any reason; or
4. The date a person ceases to be a Dependent as defined in the policy, but only with respect to such person.**]]**

Continuation Coverage

Federal law requires certain employers to offer continuation coverage to Employees for a specified period of time upon termination of employment or reduction of work hours for any reason other than gross misconduct. You should contact your Employer to find out whether or not this requirement applies to you and your Employer. Your employer will advise you of your rights to continuation coverage, if any, and the cost. If this requirement does apply, you must elect to continue coverage within 60 days from your qualifying event or notification of rights by your Employer, whichever is later. [[You may elect to extend coverage for your eligible Dependent(s), or your eligible Dependent(s) may elect to continue coverage under certain circumstances or qualifying events. Dependent(s) must elect to continue coverage with 60 days from the event or notification of rights by your Employer, whichever is later.]] You must pay the required premium for continuation coverage directly to your Employer. We are not responsible for determining who is eligible for continuation coverage. If This Plan contains a continuance provision that is mandated by a state law, Covered Persons eligible under that provision will have the choice of electing: 1) the state continuance coverage and subsequently the federal continuance coverage, if allowed by state law; or 2) the federal continuance alone. **]**

PART 10: GENERAL DENTAL PROVISIONS

[Proofs of Claim

Proof of claim must be sent to us in writing within 90 days of the Incurred Date of the dental treatment. If such Proof cannot be sent within this time limit, it must be sent as soon as reasonably possible, but not later than 12 months of the Incurred Date.

Such Proofs of claim must be made on the forms we require. If such forms are not available due to our failure to furnish them upon request of the Policyholder [[or Employer]], your compliance with the remaining terms of this section will satisfy your responsibility to us regarding Proofs of claim.

You [[and all persons covered under the policy]] are required to furnish any information that we may reasonably require to review your Proof of claim. If you [[or other Covered Persons]] fail to furnish information we require to verify the eligibility or insurability of you [[or other Covered Persons]], we reserve the right to terminate or rescind such coverage. Also, we have the right to require any of the following:

1. A complete dental chart showing:
   a) extractions;
   b) missing teeth;
   c) fillings;
   d) prostheses;
   e) periodontal pocket depths; and
   f) the date of any work previously performed.
2. An itemized bill for all dental care.
3. The following exhibits:
   a) x-rays;
   b) study models;
   c) laboratory and/or hospital records.
4. A dental examination at our expense by a Dentist whom we choose.

[[5. Completion of a brief questionnaire which will specify:
   a) the degree of overjet, overbite, crowding, open bite;
   b) if teeth are impacted in crossbite, or congenitally missing;
   c) the length of treatment; and
   d) the total charge for the treatment.]]

6. Any additional information we may need to process your claim. If you [[or other covered persons]] fail to furnish information we require to verify [the eligibility of you] [[or other covered persons]], we reserve the right to terminate or rescind such coverage.

If you [[or any other covered person]] commits an act of fraud in attempting to secure benefits from us, we may terminate or rescind your [[(and your Dependents)]] coverage [[or the coverage of the person who commits such act]].

If we rescind coverage, we will refund any premium paid less any claim reimbursements.

Legal Actions

For 60 days after written Proof of claim, as required by us, has been filed, no legal or equitable action may be brought against us for that claim. No action at all may be brought against us after 3 years from the date on which written Proof of claim is required.]

[Workers' Compensation

This insurance does not take the place of or affect any requirement for coverage by Workers' Compensation Insurance.

Non-Discrimination

In the administration of This Plan, the Policyholder [[and the Employer]] are obligated to treat you and other [Employees] in like situations fairly.

Time Periods

All time periods referred to in the policy will begin and end at 12:01 A.M. standard time at the [Employer's] home office.]

Disclosure of Information
Group Dental Plan

The following document provides you with information regarding your Group Dental Benefits. This document is intended to clarify and to provide additional information about your plan. Your Group Certificate provides detailed provisions of coverage including any limitations or restrictions that apply. **You should read your certificate carefully.**

[[Dental Network

Our group dental insurance program utilizes a nationwide network of dentists. [United Concordia] is the dental network administrator used by us and is responsible for the development and management of our participating provider networks. [United Concordia] strives to provide the most comprehensive network of dentists possible in all areas across the country. All providers have the right to participate in the network provided all enrollment criteria is met and they are willing to meet the terms and conditions for participation. Key features of this plan include:

- You may receive services from a provider of your choice
- You may receive a higher level of benefits for dental services when choosing a participating provider

Provider Directories

You may obtain provider directories by contacting us at [800-451-2513] or you may view the list of participating providers on our web site at [http://ebg.sunlife.com.] It is possible that a provider may have left or joined the network since the printing of the directory. You may contact us in order to verify that a provider is a participant.

Provider Contracts

PPO provider contracts do not include "gag" clauses. Contracts do not prohibit the provider from discussing available treatment options and services or from disclosing the compensation methodology to covered persons.]]

Financial Arrangements

Reimbursements are based on various factors. Payment may be based on the Maximum Allowable Charge, Usual Charge or the Customary Charge by a participating provider. The provider is not given an incentive or bonus that encourages withholding service or influences referrals to specialists. If you would like additional information about how providers are compensated, please contact us at the telephone number listed on your ID card.

Covered Expenses

Pre-Determination of Benefits

Pre-Determination of Benefits is recommended for extensive treatment such as root canal therapy, crowns, bridges and periodontal treatment, if such services are included under This Plan. We recommend that the DENTAL TREATMENT PLAN be submitted to us for review before treatment begins. We will notify you and the Dentist of the benefits payable based upon the DENTAL TREATMENT PLAN. In determining the amount of benefits payable, consideration will be given to Alternate Dental Treatment that will, as determined by us, accomplish a professionally satisfactory result. If you and the Dentist agree to a more costly method of treatment, than that determined by us, the excess amount will not be paid by us. Pre-determination of Benefits is not required and failure to submit a Pre-Determination of Benefits does not affect the amount of benefits payable by us.

Pre-Determination of Benefits is not a guarantee of benefits under your dental plan. You or your dependent must meet the plan's eligibility requirements and services must be covered expenses for benefits to be payable. Please be sure to read your certificate carefully to ensure coverage is provided under your plan.

Retrospective Review

Certain claims are subject to retrospective review to determine whether the supplies or services provided are essential as required by your plan. Other than expenses for which coverage is required by state law, expenses for treatment or supplies that are not essential are not covered by your plan.

Description of Benefits

The *Insurance Schedule* and *Dental Expense Benefits: Covered Expenses* parts of your Group Certificate contain information regarding benefits including benefit maximums and limitations. The *Insurance Schedule* part outlines the benefit levels for treatment including information about your responsibility for payment related to coinsurance, co-payments, deductibles and annual limits. If services are not covered by the plan, you are responsible for payment.

The *Dental Expense Benefits: Exclusions* part of your Group Certificate contains information about charges for which no benefits are paid. Benefits are payable for essential treatment, subject to all of the provisions of your Group Certificate.

Confidentiality of Patient Information

Dental records and other patient information will be released only upon written authorization from the insured. Such information may only be used to determine eligibility and benefits payable under the plan. All employees take appropriate measures to safeguard the security and confidentiality of patient information.

[[Rights and Responsibilities

We are committed to treating all our enrollees in a manner that respects their rights under this contract. We expect the providers of care to treat our enrollees as they would any other patient in terms of care provided, accommodations, and timeliness of access to care. We do not solicit enrollee satisfaction information.]]

Grievance Process:

If you disagree with a claim decision made by us, within 180 calendar days of receipt of such claim decision, you, your dentist, or your representative may call us at the toll-free telephone number listed on your ID card to initiate an appeal.

SUN LIFE ASSURANCE COMPANY OF CANADA certifies that it has issued and delivered a Certificate Amendment to

POLICYHOLDER: THE POLICYHOLDER NAMED ON THE FACE PAGE OF THE GROUP CERTIFICATE

EFFECTIVE DATE: THE DATE THE TERMS OF THIS CERTIFICATE AMENDMENT BECOME APPLICABLE TO THE EMPLOYER AS SHOWN IN THE EMPLOYER'S PLAN OF INSURANCE

AMENDING GROUP POLICY NO.: THE POLICY NUMBER SHOWN ON THE FACE PAGE OF THE GROUP CERTIFICATE AND THAT IS APPLICABLE TO DENTAL INSURANCE

This Certificate Amendment forms a part of your Group Certificate which describes the provisions of the group policy specified above.

The Certificate is changed as follows:

A. The following dental services related to the treatment of Temporomandibular Joint Disorder (TMD) and Craniomandibular Disorder (CMD) are added to [Type [II] Covered Dental Expenses in] the COVERED DENTAL EXPENSES part:

Service	Special Limitations
Cephalometric X-ray	Limited to once per lifetime for TMD/CMD services.
Tomographic survey	Limited to 1 time in any 5 Calendar Years.
Other TMJ films that are not included in [Type I] Covered Dental Expenses	Limited to 1 time in any 5 Calendar Years.
Occlusal orthotic device	
Occlusal guard	
Occlusion analysis – mounted case	
Occlusal adjustment – Limited or complete	

B. The Special Limitations section for the following Covered Expenses is changed to read as follows:

Service	Special Limitations
Oral Evaluations: Comprehensive and Periodic	Limited to 2 of these services in any 12 consecutive month period. Comprehensive evaluations are limited to one time per dental office unless there is a significant change in dental health or if the patient is absent from the office for 3 or more years. Detailed and extensive oral evaluations for TMD/CMD dental services are limited to [one per 12 month] period. These evaluations are in addition to routine periodic evaluations.
Full mouth X-rays	Limited to one complete series in any [60 consecutive month period] and one panorex for TMD/CMD services in any [5 Calendar Year] period.

C. Any TMD/CMD services not specifically listed above are not Covered Expenses under this amendment and are subject to the Exclusions part of the Certificate.

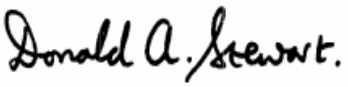
D. Covered Expenses listed in item A above [[are payable at [50%} and]] will not be subject to the Per Person Deductible.

E . Covered Expenses listed in item A above will be subject to a [lifetime] maximum benefit of [$2,000] [and will be applied toward the Per Person Calendar Year Maximum Benefit].

[[F. A six month Benefit Waiting Period will be applied to TMD/CMD services.]]

Nothing contained in this Certificate Amendment will be held to affect any of the terms of the Group Certificate other than as stated herein.

This Certificate Amendment is part of the Group Certificate. It should be kept with your Group Certificate which contains the principal provisions of the group policy.



Chief Executive Officer

SUN LIFE ASSURANCE COMPANY OF CANADA certifies that it has issued and delivered a Certificate Amendment to

POLICYHOLDER: THE POLICYHOLDER NAMED ON THE FACE PAGE OF THE GROUP CERTIFICATE

EFFECTIVE DATE: THE DATE THE TERMS OF THIS CERTIFICATE AMENDMENT BECOME APPLICABLE TO THE EMPLOYER AS SHOWN IN THE EMPLOYER'S PLAN OF INSURANCE

AMENDING GROUP POLICY NO.: THE POLICY NUMBER SHOWN ON THE FACE PAGE OF THE GROUP CERTIFICATE AND THAT IS APPLICABLE TO DENTAL INSURANCE

This Certificate Amendment forms a part of your Group Certificate which describes the provisions of the group policy specified above.

The Certificate is changed as follows:

A. For the purposes of the benefit provided by this amendment, the Alternate Dental Treatment provision is deleted from the Determination of Benefits part.

B. The following implantology services are added to [Type [III] Covered Dental Expenses in] the COVERED DENTAL EXPENSES part:

Service	Special Limitations
Surgical placement of implant	Limited to one per tooth per lifetime and to Covered Persons who are 18 or older.
Implant Removal	
Implant/Abutment Supported Removable and Fixed Dentures	
Single Crown, Implant or Abutment Supported	
Fixed Partial Denture, Implant or Abutment Supported	.
Surgical repair procedures performed to support placement of dental implant	

C. The Exclusions part is changed as follows:
   1 The exclusion beginning “Implants and any related surgery, placement”…. is deleted.
   2. The following exclusion is added:
   Implantology services are excluded if such services are performed to replace one or more teeth missing prior to the Covered Person’s Effective Date.

D. Covered Expenses for the services described in item B above will not be subject to The Per Person Cash Deductible but will be applied toward the [Calendar Year] Maximum Benefit.

[[E. Covered Expenses shown in item B are payable at [50%].]]

Nothing contained in this Certificate Amendment will be held to affect any of the terms of the Group Certificate other than as stated herein.

This Certificate Amendment is part of the Group Certificate. It should be kept with your Group Certificate which contains the principal provisions of the group policy.

Donald A. Stewart.

Chief Executive Officer

GROUP CERTIFICATE AMENDMENT: IMPLANT

GC-CA IMPLANT

SUN LIFE ASSURANCE COMPANY OF CANADA certifies that it has issued and delivered a Certificate Amendment to

POLICYHOLDER: THE POLICYHOLDER NAMED ON THE FACE PAGE OF THE GROUP CERTIFICATE

EFFECTIVE DATE: THE DATE THE TERMS OF THIS CERTIFICATE AMENDMENT BECOME APPLICABLE TO THE EMPLOYER AS SHOWN IN THE EMPLOYER'S PLAN OF INSURANCE

AMENDING GROUP POLICY NO.: THE POLICY NUMBER SHOWN ON THE FACE PAGE OF THE GROUP CERTIFICATE AND THAT IS APPLICABLE TO DENTAL INSURANCE

This Certificate Amendment forms a part of your Group Certificate which describes the provisions of the group policy specified above.

The Certificate is changed as follows:

A. The following non-surgical periodontal services are added to [Type [II] Covered Dental Expenses in] the COVERED DENTAL EXPENSES part:

Service	Special Limitations
Collection of Micro-organisms for culture and sensitivity	One per lifetime.
Caries susceptibility tests	One per lifetime.
Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	Limited to 2 times in any 12 consecutive month period and to Covered Persons under the age of 14. The age limitation will not apply to a Covered Person who has had surgical periodontal treatment.
Full mouth debridement to enable comprehensive evaluation and diagnosis	
Brush biopsy – transepithelial sample collection	One per lifetime.

[[Covered Expenses are payable at [50%] .]]

B. [[The following is added to Type III Covered Dental Expenses in the COVERED DENTAL EXPENSES part:

Service	Special Limitations
Localized delivery of time release anti-microbial agents into diseased crevicular tissue	6 per 12 consecutive months.]]

[[The following service is added to the COVERED DENTAL EXPENSES part:

Localized delivery of antimicrobial agents into diseased crevicular tissue subject to a limitation of 6 per 12 consecutive months. Covered Expenses are payable at [50%].]]

C. Covered Expenses for the services described in items A and B above, will not be subject to the Per Person Deductible and will be applied toward the [Calendar Year] Maximum Benefit.

Nothing contained in this Certificate Amendment will be held to affect any of the terms of the Group Certificate other than as stated herein.

This Certificate Amendment is part of the Group Certificate. It should be kept with your Group Certificate which contains the principal provisions of the group policy.

Donald A. Stewart.

Chief Executive Officer

GROUP CERTIFICATE AMENDMENT: NS-PERIO

SUN LIFE ASSURANCE COMPANY OF CANADA certifies that it has issued and delivered a Certificate Amendment to [[the Policyholder shown on the face page of the Certificate(s) for Employees of the Employer shown below.]]

[[POLICYHOLDER]] [[EMPLOYER]]: [ABC COMPANY]

EFFECTIVE DATE: [AUGUST 1, 2010]

AMENDING GROUP POLICY NO: THE POLICY NUMBER THAT IS SHOWN ON THE FACE PAGE OF THE GROUP CERTIFICATE(S) THAT IS APPLICABLE TO DENTAL INSURANCE

This Certificate Amendment forms a part of your Group Certificate which describes the provisions of the group policy specified above.

For the purposes of this Certificate Amendment:

Prior Policy means the group policy issued by Sun Life and Health Insurance Company (U.S.) to the Policyholder. Prior to December 1, 2007, Sun Life and Health Insurance Company (U.S.) was known as Genworth Life and Health Insurance Company. Prior to March 24, 2006, Genworth Life and Health Insurance Company was known as GE Group Life Assurance Company. And prior to January 1, 2001, GE Group Life Assurance Company was known as Phoenix American Life Insurance Company.

This Policy means the Group Policy issued by Sun Life Assurance Company of Canada to the Policyholder.

The following provisions apply to an insured person who was covered under the Prior Policy on the day before the effective date of [[the Employer's participation under]] This Policy:

1. Any representation made for the purposes of obtaining or continuing insurance under the Prior Policy shall be deemed to have been made also for the purposes of obtaining insurance under This Policy. However, for the sole purpose of applying the section entitled "Limits On Our Right To Contest", if any, the effective date of an Employee's coverage under the Prior Policy shall be deemed the effective date of the Employee's coverage under This Policy.
2. For the purposes of determining any waiting period (by whatever name called) before insurance becomes effective or benefits become payable under This Policy, credit will be given for the completion or partial completion of any waiting period under the Prior Policy.
3. For the purposes of determining any coinsurance or cash deductible provisions under This Policy, credit will be given for any coinsurance and/or cash deductible provisions satisfied or partially satisfied under the Prior Policy.
4. For the purposes of determining any benefit maximum, duration or limitation of benefits under This Policy, all benefits paid under the Prior Policy with respect to any person shall be deemed to have been paid as benefits under This Policy with respect to any person. All periods of time with respect to which benefits were paid under the Prior Policy shall be deemed to be periods of time with respect to which benefits were paid under This Policy.
5. Any request[, election, designation of beneficiary or assignment] made under the Prior Policy which continued in effect under such policy through [September 30, 2010] shall be deemed to have been made under This Policy as of the time originally made under the Prior Policy to take effect under This Policy as of [October 1, 2010].
6. Any uninterrupted period of time continuing through [September 30, 2010] during which insurance was in force under the Prior Policy with respect to any person, shall be deemed included in the period of time insurance for said person was in effect without interruption under This Policy.
7. In no event will any benefit be payable under This Policy which duplicates any benefit payable under the Prior Policy.

In the event of a conflict between This Policy and the Prior Policy, the terms of This Policy will control.

Nothing contained in this Certificate Amendment will be held to affect any of the terms of the policy as outlined in the Group Certificate other than as stated herein.

This Certificate Amendment is part of the Group Certificate. It should be kept with your Group Certificate which contains the principal provisions of the group policy.

[Donald A. Stewart.]

[Chief Executive Officer]

SERFF Tracking Number:	*SNLF-126870003*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*48103*
Company Tracking Number:	*SLOC DENTAL 2010*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*Dental filing /*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	03/02/2011

Comments:

Attachment:

AR Readability Cert.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	03/02/2011

Bypass Reason: n/a

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Explanation of Variables	Approved-Closed	03/02/2011

Comments:

Attachments:

EOV GP-A-5 (11).pdf

EOV GC-A-1 _11_.pdf

		Item Status:	Status Date:
Satisfied - Item:	Forms List	Approved-Closed	03/02/2011

Comments:

Attachment:

Forms List.pdf

CERTIFICATE OF COMPLIANCE

This is to certify that the attached Form Numbers GP-A 5 (11) et al have achieved the Flesch Reading Ease Scores shown below and comply with the requirements of Arkansas Stat. Ann. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form	Flesch Score
GP-A-5 (11)	62.5
GC-A-1 (11) et al.	58.1
GC-CA TMD-CMD	58.9
GC-CA IMPLANT	63.7
GC-CA NS-PERIO	54.6
GC-CA T10	63.5

SUN LIFE ASSURANCE COMPANY OF CANADA

Linda W. Murphy

Linda W. Murphy
Associate Director

Explanation of Variability
Group Policy of Incorporation Form GP-A-5 (11)

The [bracketed] and/or underscored material is intended to be illustrative and variable to accommodate the requirements of individual policyholders.

FORM #	PROVISION	VARIATION
GP-A-5	Computing Employer and Employee Premiums	Employer may vary to read Policyholder. Policyholder may vary to read Employer. Employee may vary to read Member.
	Changes in Computing Premium	Text in double brackets may be omitted when policy is not issued to a trustee group. Employer may vary to read Policyholder. Policyholder may vary to read Employer. Employee may vary to read Member Rate Guarantee may vary from 6 through 36 months. Number of Employees in item 4 may vary from 4 through 10 Rates included will vary in accordance with particular policyholder's plan of insurance and the benefits and provisions relating thereto.

Explanation Of Variability
Forms GC-A-1 (11), et al

The [bracketed] and/or underscored material is intended to be illustrative and variable to accommodate the requirements of individual policyholders. Text in [[double brackets]] may be included as submitted or deleted in its entirety. Coverage for Type II, III and/or IV Expenses may be omitted and any references to such expenses will be deleted. Procedures within an Expense Type may be moved to another Expense Type. Any reference to dependents will be deleted if the Employer chooses to provide coverage for employees only. References to Calendar Year may be changed to Benefit Year at the Policyholder's request. Language may be changed to reflect benefits mandated by your state laws or regulations or federal legislation. In addition, language may vary as follows:

Form #	Provision	Variation
GC-A-1 (11)	Employee	Will vary to include all of the employer's employees or members in a union or all of any class or classes thereby determined by conditions pertaining to their employment/ membership. When pertaining to membership, any references to Employee(s) will be changed to Member(s)
	Date of Eligibility	Determined by policyholder based on conditions pertaining to employment/membership
	Schedule of Dental Benefits	Reflects plan design and Policyholder selection; deductible may vary between $0 and $500; the maximum family deductible may be deleted or may be up to three times the per person deductible; the deductible may be Calendar Year or Lifetime; the deductible may be excluded, apply to all expense types apply to Type II and III expenses only or apply to type III expenses only; deductible for Type IV expenses may be applied separately; the deductible for Type I expenses may be waived for Type I Network expenses; the per person maximum benefit may vary between $100 and unlimited. The maximum family benefit may be deleted or may be up to three times the per person maximum benefit; The calendar year maximum may apply to coverage for Type I, II and/or III expenses, type II and/or III expenses or only to Type III expenses; coverage for Type II, Type III and/or Type IV expenses may be omitted and any references to such expenses will be deleted; reference to dependent coverage will be deleted if the Policyholder chooses to provide coverage for employees only;. Network coinsurance may vary as follows: Type I - 10%-100%, Type II –10%-100%, Type III – 10%-100%, Type IV – 10%-100%. Out-of-Network Coinsurance may vary as follows: -: Type I - 10%-100%, Type II – 10%-100%, Type III – 0-100%, Type IV – 10%-100%. **The in-network and out-of-network coinsurance differential cannot exceed 25%.** Benefits payable will be in accordance with Policyholder selection; Non-Network expenses may be based on Usual and Customary Charges or Maximum Allowable Charges.
GC-A-3 (11)	Actively At Work	References to actively at work requirements and Employer may be omitted, references to employment may be changed to membership and references to employee may be changed to member when the policy is to cover groups other than employer/employee groups. References to full-time employment will be omitted when part-time employees are covered.
	Calendar Year	Calendar Year paragraph may be deleted and Benefit Year paragraph will be included.
	Child	Age may vary based on policyholder selection and state mandates. May be omitted for Employee only coverage. Child age may vary from 19 to 26 in one year increments. Requirements regarding financial support, marital and/or student status may be deleted. May include coverage for child of a domestic partner when such coverage is requested by the policyholder or required by state mandates.
	Covered Person	Will vary to omit reference to dependents when dependent coverage is not provided.

	Dental Prophylaxis	Text that begins “For benefits purposes”…. will be omitted when the policyholder has elected to provide coverage for periodontal maintenance.
	Dependent	May be omitted when dependent coverage is not provided. Domestic Partner may be included when requested by the policyholder. Item 2-a may be deleted if requested by the Policyholder.
	Domestic Partner	May be included if requested by the Policyholder.
	Eligible Employee	References to Employee may be changed to Member. Item 3 and the item beginning “ If your earnings’… may be deleted if requested by the Policyholder.
	Employee	May vary to include all of the employer’s employees or members in a union or all of any class/classes determined by conditions pertaining to employment/membership. When pertaining to membership, any references to Employee will be changed to Member. References to Employer/Employer’s may be changed to Policyholder/Policyholder’s.
	Employer (Eligible Employer)	References to Employer may be changed to Policyholder.
	Full-time Student	Will be omitted when Dependent coverage is not included or policyholder’s plan does not require full-time student status.
	Handicapped Child	Will be omitted when Dependent coverage is not included. References to full-time student status will be deleted when policy has no full-time student requirement. Reference to the Employer/Eligible Employer may be changed to policyholder. Ages will vary in accordance with policyholder request and state mandates.
	Late Entrant	May be omitted based on plan design
	Open Enrollment Period	May be included based on plan design, bracketed text may be included based on plan design.
	Orthodontic Treatment	May be omitted based on plan design
	Qualified Status Change	Reference to Domestic Partner may be deleted based on Employer selection
	Retired Employee	May be included based on policyholder requirements. Employee may be changed to Member.
	You	Employee may be changed to Member.
GC-A-4 (11)	Date of Eligibility (Waiting Period)	References to employment may be changed to membership and references to employee may be changed to member when the policy is to cover groups other than employer/employee groups. References to full-time employment will be omitted when part-time employees are covered.
	Conditions of Insurability	Employee/Employer may be changed to Member/Policyholder. Text beginning “If you submit’… may be omitted in its entirety. May include Open Enrollment or Late Entrant Provision; 31 days may vary to 60 days
	Effective Date of Insurance	Text referencing Open Enrollment Period may be omitted based on plan design.
	Voluntary Disenrollment	May be omitted in its entirety based on plan design.
	Benefit Waiting Periods	May be deleted based on Policyholder selection; reference to Benefit Waiting Periods for Types II, III and/or IV expenses may be deleted based on Policyholder selection. Waiting periods range from 1 month through 36 months. Benefit Waiting Periods may apply to all employees or new employees only.
	Limitation on Late Entrants	Entire provision may be omitted based on policyholder selection. Coverage for Type II expenses may be deferred for up to 12 months after a covered person has been insured. Coverage for Type III and/or IV Expenses may be deferred for up to 24 months after a covered person has been insured.

GC-A-5 (11)	Dependent Coverage	Part may be omitted when the policyholder does not elect dependent coverage.
	Date of Eligibility	Domestic partner reference may be omitted based on Policyholder selection. Text that begins “If you and your spouse”…. May be omitted based on policyholder selection. Reference to “or Domestic Partner” will be omitted when such coverage is not included.
	Conditions of Insurability	Item 5 may be omitted in its entirety; may include Open Enrollment or Late Entrant provision; 31 days may vary to 60 days.
	Effective Date of Insurance	Based on plan design, may include Open Enrollment Period language
	Voluntary Disenrollment	May be omitted in its entirety based on plan design.
	Benefit Waiting Periods	May be deleted based on Policyholder selection; reference to Benefit Waiting Periods for Types II, III and/or IV expenses may be deleted based on Policyholder selection. Waiting periods range from 1 month through 36 months. Benefit waiting periods may apply to dependents of all employees or dependents of new employees only.
	Limitation on Late Entrants	Entire provision may be omitted based on policyholder selection. Coverage for Type II expenses may be deferred for up to 12 months after an Employee has been insured. Coverage for Type III and/or IV Expenses may be deferred for up to 24 months after a covered person has been insured.
GC-A-6 (11)	Conditions Under Which Benefits Are Payable	May vary based on policyholder selection of Calendar Year and Lifetime Maximums for Types I, II, III, and IV Expenses.
	Benefits Payable with respect to Type I, Type II and Type III COVERED DENTAL EXPENSES	Reference to Type II and/or III Expenses may be omitted based on plan design; reference to deductible may be omitted based on plan design.
	Benefits Payable for Type IV COVERED DENTAL EXPENSES	Entire provision may be omitted when orthodontic coverage is not provided.
	Deductible	May vary based on Policyholder selection: deductible may be Calendar Year or Lifetime, Family deductible may be deleted, 3 month carryover may apply; separate deductible for Network and Non-Network expenses may apply.
	Calendar Year Maximum Benefit	May vary based on Policyholder selection: reference to Type II and/or Type III expenses may be deleted; may include Type IV Calendar Year maximum; separate maximums for Network and Non-Network expenses may apply.
	Lifetime Maximum Benefit	May be included when Policyholder selects Type IV coverage; separate maximums for Network and Non-Network expenses may apply; alternate text for Lifetime Maximum Benefit provision may be included based on plan design.

GC-A-7 (11)	Covered Dental Expenses: Type I Dental Services	Text may vary to indicate that benefits for charges by Non-Participating Providers are the lesser of the Usual Charge or the Customary Charge or the lesser of the Usual Charge or Customary Charge or the Maximum Allowable Charge. Frequencies may vary to reflect plan design and Policyholder selection; procedures may be moved to a different expense type based on policyholder selection. Procedures that are specific to dependent children, i.e. sealants will be omitted when there is no dependent coverage.
	Oral Evaluations: Comprehensive and Periodic	Frequency options include: Limited to 1 time in any 6 consecutive month period. Limited to 1 time in any 12 consecutive month period. Limited to 2 times in any 12 consecutive month period Limited to 1 time in any 18 consecutive month period Limited to 1 time in any 24 consecutive month period Limited to 1 time in any 36 consecutive month period Limited to 1 per Calendar Year Limited to 2 per Calendar year No frequency limit
	Oral Evaluations: Consultations and Limited Problem Focused	Frequency options include: Limited to 1 time in any 6 consecutive month period. Limited to 1 time in any 12 consecutive month period. Limited to 2 times in any 12 consecutive month period Limited to 1 time in any 18 consecutive month period Limited to 1 time in any 24 consecutive month period Limited to 1 time in any 36 consecutive month period Limited to 1 per Calendar Year Limited to 2 per Calendar Year No frequency limit.

	Oral Evaluation: Detailed Problem focused	Frequency options include: Limited to 1 time in any 6 consecutive month period. Limited to 1 time in any 12 consecutive month period. Limited to 2 times in any 12 consecutive month period Limited to 1 time in any 18 consecutive month period Limited to 1 time in any 24 consecutive month period Limited to 1 time in any 36 consecutive month period Limited to 1 per Calendar Year Limited to 2 per Calendar Year No frequency limit.
	Bite-wing X-rays	Frequency options include: Limited to 1 set in any 6 consecutive month period Limited to 1 set in any 12 consecutive month period Limited to 2 sets in any 12 consecutive month period. Limited to 1 set in any 18 consecutive month period Limited to 1 set in any 24 consecutive month period Limited to 1 set in any 36 consecutive month period Limited to 1 set per Calendar Year. Limited to 2 sets in any Calendar Year. No frequency limit. Age limitations may be excluded or age may vary from 14 through 19. Item may be deleted in its entirety if coverage is for all x-rays with no frequency limitations.
	Dental Prophylaxis	Frequency options include: No limit Limited to 1 time in any 3 consecutive month period Limited to 1 time in any 4 consecutive month period Limited to 1 time in any 6 consecutive month period Limited to 1 time in any 12 consecutive month period. Limited to 2 times in any 12 consecutive month period Limited to 1 time in any 18 consecutive month period Limited to 1 time in any 24 consecutive month period Limited to 1 time in any 36 consecutive month period Limited to 1 per Calendar Year Limited to 2 per Calendar Year Limited to 3 per Calendar Year Limited to 4 per Calendar Year
	Fluoride Treatments	May be deleted for Employee only plans. Child age may vary from 14 through 19. Frequency options include: Limited to 1 time in any 6 consecutive month period Limited to 1 time in any 12 consecutive month period Limited to 2 times in any 12 consecutive month period Limited to 1 time in any Calendar Year Limited to 2 times in any Calendar Year No frequency limit.

	Space Maintainers	May be deleted for Employee only plans. Child age may vary from 14 through 19. Frequency options include: Limited to [1][2] per Calendar Year Limited to [1][2] in any 2 year period Limited to [1][2] in any 3 year period Limited to [1][2] in any 4 year period Limited to [1][2] in any 5 year period
	Sealants	Child age may vary from 14 through 19. Frequency options include: Limited to [once][twice] per lifetime .Limited to [once][twice] in any 2 year period. Limited to [once][twice] in any 3 year period. Limited to [once][twice] in any 4 year period. Limited to [once][twice] in any 5 year period. Limited to [once][twice] in any 24 consecutive months. Limited to [once][twice] in any 36 consecutive months. Limited to [once][twice] in any 48 consecutive months. Limited to [once][twice] in any 60 consecutive months.
	Type II Dental Services	Text regarding benefit waiting periods may be omitted based on plan design. Text beginning "This Benefit waiting period will not be" ….will be included when a waiting period is applicable only to new employees; frequencies may vary to reflect plan design and Policyholder selection; procedures may be moved to a different expense type based on policyholder selection; may be omitted in its entirety based on policyholder selection.
	Full Mouth X-rays	Frequency options include: Limited to 1 in any [60 consecutive month period][5 Calendar Years]. Limited to 1 in any [48 consecutive month period][4 Calendar Years]. Limited to 1 in any [36 consecutive month period][3 Calendar Years.]. Limited to 1 in any [24 consecutive month period][2 Calendar Years} Limited to 1 in any [12 consecutive month period][Calendar Year]. No frequency limitation
	Amalgam Restoration	Frequency options include: Limited to 1 time in any 12 consecutive month period Limited to 1 time in any 18 consecutive month period Limited to 1 time in any 24 consecutive month period Limited to 1 time in any 36 consecutive month period No frequency limitation
	Composite Restoration	Frequency options include: Limited to 1 time in any 12 consecutive month period Limited to 1 time in any 18 consecutive month period Limited to 1 time in any 24 consecutive month period Limited to 1 time in any 36 consecutive month period No frequency limitation. Option to cover on posterior teeth.
	Stainless Steel Crowns	Age may vary from 14 through 19.

	Recement Cast Post, Inlays, Crowns, Bridges	Frequency options include: 1 in any 6 consecutive months 1 in any [12 consecutive months][Calendar Year] 1 in any [24 consecutive months][2 Calendar Years No frequency limitation.
	Pulpal Therapy	Text beginning " Eligible teeth are . . . " may be omitted
	Scaling and Root Planing	Option to exclude coverage. Frequency options include: Limited to 1 time per quadrant in any [12 consecutive month period.][Calendar Year]. Limited to 1 time per quadrant in any 18 consecutive month period. Limited to 1 time per quadrant in any [24 consecutive month period.][2 Calendar Years]. Limited to 1 time per quadrant in any [36 consecutive month period.][3 Calendar Years.] Limited to 1 time per quadrant in any [48 consecutive month period.][4 Calendar Years]. No frequency limitation
	Periodontal Maintenance	Frequency options include : Limited to 1 per Calendar Year. Limited to 2 per Calendar Year. Limited to 3 per Calendar Year. Limited to 4 per Calendar Year. Limited to 1 time in any 12 consecutive month period. Limited to 2 times in any 12 consecutive month period. Limited to 3 times in any 12 consecutive month period. Limited to 4 times in any 12 consecutive month period.
	Surgical Periodontal Procedures	Option to exclude coverage. Frequency options include: One procedure per area of the mouth in any [12 months][Calendar Year] One procedure per area of the mouth in any 18 months One procedure per area of the mouth in any [24 months][2 Calendar Years] One procedure per area of the mouth in any [36 months][3 Calendar Years] No frequency limit
	Type III Dental Services	Text regarding benefit waiting periods may be omitted based on plan design. Text beginning "This Benefit waiting period will not be" ….will be included when a waiting period is applicable only to new employees; frequencies may vary to reflect plan design and Policyholder selection; procedures may be moved to a different expense type based on policyholder selection. May be omitted in its entirety based on policyholder selection.
	Crown Buildup or Core Buildup	Frequency options include: Limited to 1 time in any [60 months][5 Calendar Years] Limited to 1 time in any [120 months][10 Calendar Years]
	Full or Partial Dentures	Frequency options include: Limited to 1 time in any [60 months][5 Calendar Years] Limited to 1 time in any [72 months][6 Calendar Years] Limited to 1 time in any [84 months][7 Calendar Years] Limited to 1 time in any [96 months][8 Calendar Years] Limited to 1 time in any [108 months][9 Calendar Years] Limited to 1 time in any [120 months][10 Calendar Years] Text beginning "See Item . . ." may be deleted based on policyholder selection.

	Relining Dentures, Rebasing Dentures or Denture Adjustments	Frequency options include: Considered part of the denture charges if provided within [6][12] months of insertion. Subsequent relining done more than 1 time in any [12 consecutive months][Calendar Year] 1 time in any [24 consecutive months][2 Calendar Years] 1 time in any [36 consecutive months][3 Calendar Years].
	Fixed Bridges	Frequency options include: Limited to 1 time in any [60 months][5 Calendar Years] Limited to 1 time in any [72 months][6 Calendar Years] Limited to 1 time in any [84 months][7 Calendar Years] Limited to 1 time in any [96 months][8 Calendar Years] Limited to 1 time in any [108 months][9 Calendar Years] Limited to 1 time in any [120 months][10 Calendar Years] Text beginning "See Item . . ." may be deleted based on policyholder selection.
	Type IV Orthodontic Dental Services	May be omitted in its entirety based on policyholder selection. Text regarding benefit waiting periods may be omitted based on plan design. Text beginning "This Benefit waiting period will not be" ….will be included when a waiting period is applicable only to new employees.
GC-A-8 (11)	Item 31	Will be included when the policyholder has not elected to provide Orthodontic coverage. Text beginning…."for Covered Persons"… will be included when the policyholder has not elected coverage for adult orthodontic treatment.
	Item 33	May be deleted when Policyholder elects to cover anesthesia for all covered persons; option to only exclude IV sedation.
	Item 32	Option to exclude coverage for replacement of teeth missing prior to the effective date of coverage; could apply to just new employees or to both initial and new employees.
	Item 34	May be included or omitted in its entirety.
GC-A-10 (11)	Termination of Employee and Dependent Insurance	If eligibility is based on membership, employee will be changed to member and item 1 will be deleted. References to Dependents will be deleted if the policyholder chooses to provide coverage to employees/members only. "On the date…" may vary to read "On the last day of the calendar month in which"…. Layoff and leave of absence provisions – 2 months may vary up to 6 months References to full-time employment will be omitted when part-time employees are covered. Item 1-e, extending coverage to retired employees may be included/omitted based on policyholder selection The first item 6 may be deleted if the policy is issued to a trustee group. The second item 6 will be deleted if the policy is not issued to a trustee group. Item 7 may be omitted based on plan design
	Termination of Dependent Coverage Only	May be omitted in its entirety when the policyholder has not elected to provide dependent coverage. Item 4 may be expanded to include termination on the last day of the calendar year in which a Dependent Child ceases to be a Full-time Student.
	Continuation Coverage	References to Employer may be changed to Policyholder. References to Dependents and all other covered persons will be deleted if the Policyholder chooses to provide coverage to employees/members only

GC-A-12 (11)	Proofs of Claim	References to Employer may be changed to Policyholder. References to Dependents and all other covered persons will be deleted if the Policyholder chooses to provide coverage to employees/members only. Item 5 will be omitted when coverage for Type IV is omitted.
	Non Discrimination	Reference to and the Employer will be deleted if if the policy is not issued to a trustee group. When pertaining to membership, any references to Employee(s) will be changed to Member(s)
GC-CA NS-Perio	Paragraph A	Coverage for specified non surgical periodontal services may be added to either Type II or III Expenses or added as a Covered Expense payable at a specified coinsurance percentage. The coinsurance may vary upward from 50% to 80%.
	Paragraph B	Coverage for specified non surgical periodontal services may be added as a Type III Expense or added as a Covered Expense payable at a specified coinsurance percentage. Coinsurance may vary upward from 50% through 80%.
	Paragraph C	Calendar Year may vary to read Benefit Year. Reference to Maximum Benefit may vary to reflect a maximum for certain expense types, i.e the Maximum Benefit for Type II and Type III expenses.
GC-CA IMPLANT	Paragraph B	Coverage for implantology services may be added to either Type II or III Expenses or added as a Covered Expense payable at a specified coinsurance percentage
	Paragraph D	Calendar Year may vary to read Benefit Year, Covered Expenses may be applied to the Calendar Year maximum benefit
	Item E	May be omitted in its entirety if benefits are payable as an expense type specified in paragraph B. Coinsurance percentage may vary from 10 through 80%.
GC-CA TMD/CMD	Paragraph A	Coverage for TMD/CMD services may be added to either Type II or III Expenses or added as a Covered Expense payable at a specified coinsurance percentage
	Tomographic Survey	Frequency may vary in one year increments from 3 through 5 Calendar Years Frequency may vary in 12 month increments from 36 through 60 consecutive months
	Other TMJ films	May vary to reference “Not included in Type II” Covered Dental Expenses Frequency may vary from 1 through 3 times Timeframes may vary in 1 year increments from 3 through 6 Calendar Years.
	Oral Evaluations	Frequency options include: Limited to 1 time in any 6 consecutive month period. Limited to 1 time in any 12 consecutive month period. Limited to 2 times in any 12 consecutive month period Limited to 1 time in any 18 consecutive month period Limited to 1 time in any 24 consecutive month period Limited to 1 time in any 36 consecutive month period Limited to 1 per Calendar Year Limited to 2 per Calendar year No frequency limit.
	Full Mouth X-rays	Frequency options include: Limited to 1 in any [60 consecutive month period][5 Calendar Years]. Limited to 1 in any [48 consecutive month period][4 Calendar Years]. Limited to 1 in any [36 consecutive month period][3 Calendar Years.]. Limited to 1 in any [24 consecutive month period][2 Calendar Years} Limited to 1 in any [12 consecutive month period][Calendar Year]. No frequency limitation

	Paragraph D	Benefit percentage may be varied from 10 through 50%. Bracketed text may be omitted if benefits are payable as an expense type specified in paragraph A.
	Paragraph E	Benefit may be either calendar year or lifetime and may be applied toward the per person Calendar Year maximum. When the benefit is a calendar year maximum, it may vary from $500 to $1,500. When the benefit is a lifetime maximum, it may vary from $500 through $6,000.
	Paragraph F	May be omitted in its entirety. Benefit Waiting Period may vary from 6 months to 3 years.

Sun Life Assurance Company of Canada
Group Dental Forms Listing

Policy Form #	**Type of Form/Description of Form**
GP-A-5 (11)	Policy- Premium Provisions
Certificate Form #	**Type of Form/Description of Form**
GC-A-1 (11)	Schedule of Dental Benefits
GC-A-3 (11)	Definitions
GC-A-4 (11)	Employee Insurance
GC-A-5 (11)	Dependent Coverage
GC-A-6 (11)	Determination of Benefits
GC-A-7 (11)	Covered Expenses
GC-A-8 (11)	Exclusions
GC-A-10 (11)	Termination Provisions
GC-A-12 (11)	General Dental Provisions
GC-A-AR DEN DISC (11)	Disclosure Form
Certificate Amendment Form #	**Type of Form/Description of Form**
GC-CA TMD/CMD	Temporomandibular Joint Disorder (TMD) Benefit
GC-CA IMPLANT	Implantology Benefit
GC-CA NS-PERIO	Enhanced Benefits for Non-surgical Periodontal Treatment
GC-CA T10	Transfer Amendment

SERFF Tracking Number:	*SNLF-126870003*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*48103*
Company Tracking Number:	*SLOC DENTAL 2010*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*Group Dental*		
Project Name/Number:	*Dental filing /*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/09/2010	Form	Certificate Form	03/02/2011	GC-A-1 (11) et al.pdf (Superceded)

PART 1: INSURANCE SCHEDULE

DENTAL EXPENSE BENEFITS
EMPLOYEE [[AND DEPENDENTS]]

Employee

EACH FULL-TIME NON-UNION EMPLOYEE

Date of Eligibility (Waiting Period):

90 DAYS

[[SCHEDULE OF DENTAL BENEFITS

Covered Expense	Per Person Deductible	Percentage of Covered Expenses Payable *	Per Person Maximum Benefit
Type I	$150.00 [[per Lifetime]] [[per Calendar Year]]	60%	Per Calendar Year: $500.00 for Type [I,] [II and] III expenses [combined].
[[Type II	$150.00 [[per Lifetime]] [[per Calendar Year]]	50%]]	
[[Type III	$150.00 [[per Lifetime]] [[per Calendar Year]]	30%]]	
[[Type IV	$150.00 [[per Lifetime]] [[per Calendar Year]]	30%	Type IV limited to: $500.00 per Lifetime]].

*After applicable Deductible.

[[Only one deductible applies per [[Calendar Year]] [[Lifetime]] if Type I, II, III, and IV Dental Expenses are Incurred.]]

[[The Maximum Family Deductible is $450.00.]]

If a Covered Person uses the services of a Participating Provider for Covered Dental Expenses, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the Maximum Allowable Charge. If a Covered Person uses the services of a Non-Participating Provider, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the provider's Usual charge.

[[Covered Expenses are determined by the Maximum Allowable Charge whether or not services are rendered by a Participating Provider.]] **]]**

[[SCHEDULE OF DENTAL BENEFITS

Covered Expense	Per Person Deductible	Percentage of Covered Expenses Payable* Network Expenses[[1]]	Non-Network Expenses[[2]]	Per Person Maximum Benefit
Type I	$150.00 [[per Lifetime]] [[per Calendar Year]] [for Non-Network Expenses only]	100%	100%	Per Calendar Year: $500.00 for Type [I,] [II and] III expenses [combined].
[[Type II	$150.00 [[per Lifetime]] [[per Calendar Year]]	90%	80%	
[[Type III	$150.00 [[per Lifetime]] [[per Calendar Year]]	60%	50%	
[[Type IV	$150.00 [[per Lifetime]] [[per Calendar Year]]	60%	50%	Type IV limited to $500.00 Per Lifetime

*After applicable Deductible.

[[Only one deductible applies per [[Calendar Year]] [[Lifetime]] if Type I, II, III, and IV dental expenses are Incurred. The deductible is waived for Type I Network Expenses.]]

[[The Maximum Family Deductible is $450.00.]]

[1 Benefits based on Maximum Allowable Charge.]

[2 Benefits based on Usual and Customary Charges.]

[[If a Covered Person uses the services of a Participating Provider for Covered Dental Expenses, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the Maximum Allowable Charge. If a Covered Person uses the services of a Non-Participating Provider, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the provider's Usual charge.]]

[[Covered Expenses are determined by the Maximum Allowable Charge whether or not services are rendered by a Participating Provider.]] **]]**

[[SCHEDULE OF DENTAL BENEFITS
NETWORK EXPENSES[1]

Covered Expense	Per Person Deductible	Percentage of Covered Expenses Payable*	Per Person Maximum Benefit
Type I	$150.00	60%	Per Calendar Year: $500.00 for Type [I,] [II and] III expenses [combined].
[[Type II	$150.00	50%]]	
[[Type III	$150.00	30%]]	
[[Type IV	$150.00	30%	Per Lifetime: $500.00 for Type IV]].

NON-NETWORK EXPENSES[2]

Covered Expense	Per Person Deductible	Percentage of Covered Expenses Payable*	Per Person Maximum Benefit
Type I	$300.00	40%	Per Calendar Year: $250.00 for Type [I,] [II and] III expenses [combined].
[[Type II	$300.00	30%]]	
[[Type III	$300.00	20%]]	
[[Type IV	$300.00	20%	Per Lifetime: $250.00 for Type IV]]

*After applicable Deductible.

Only one deductible applies if Type I, II , III and IV expenses are Incurred. The deductible is waived for Type I Network Expenses.

[[The Maximum Family Deductible for Network Expenses is $300.00 and for Non-Network Expenses is $900.00.]]

The Per Person Maximum Benefit for Network and Non-Network Expenses combined is:

a) $500.00 per Calendar Year for Type I, II and III expenses [combined]; and

b) $500.00 per Lifetime for Type IV expenses.

[1 Benefits based on Maximum Allowable Charge.]

[2 Benefits based on Usual and Customary Charges].

If a Covered Person uses the services of a Participating Provider for Covered Dental Expenses, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the Maximum Allowable Charge. If a Covered Person uses the services of a Non-Participating Provider, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the provider's Usual Charge.]

[[Covered Expenses are determined by the Maximum Allowable Charge whether or not services are rendered by a Participating Provider.]] **]]**

PART 2: DEFINITIONS

[Accidental Bodily Injury

A bodily injury resulting directly from an accident, and independently of all other causes.

Actively At Work

You are actively at work on any day if on that day you are:

1. Working at your Employer's usual place of business or at such place or places that the Employer's normal course of business may require;
2. Performing all of the duties of your job on a full-time basis; and
3. Not confined in any institution providing care or treatment of physical or mental infirmities.

[[Open Enrollment Period

A specified period each year, determined by the Employer, when you may elect to purchase or cancel your Dental Insurance [or elect to become covered under an alternate plan of Dental Expense Benefits made available by the Employer and provided by us.]]]

[Calendar Year

[The period beginning on [January 1st] and ending on [December 31st] of the [same] year.]

[Benefit Year

A 12 month period determined by your Employer during which plan features such as deductibles and maximums accumulate and during which plan limitations may apply.]

[[Child

The term "Child":

1. Means a child who:
   - [a) is unmarried;
   - b) is receiving more than 50% of support from you; or has been recognized as having the right to benefits under This Plan under a qualified medical child support order or other similar court decree; and
   - c) is either:
     - i) under 19 years of age; or
     - [[ii) a Full-time Student and under 25 years of age; or]]
     - iii) a Handicapped Child as defined below; and
2. Is limited to:
   - a) your natural born child or other child related to you by blood;
   - b) your stepchild;
   - c) your foster child;
   - d) your legally adopted child or child placed with you pending adoption; and]
   - [[e) the child of your Domestic Partner;]] [and
3. Is subject to this restriction: No Child will be considered as a Dependent of more than one insured Employee.] **]]**

Covered Person

You [or your Dependent] who is insured for Dental Expense Benefits.

Customary Charge

A fee level selected by your Employer based on the amount standardly charged by most dental offices in the locality where the charge for a service is Incurred. Locality means an area whose size is large enough, as determined by us, to give an accurate representation of standard charges for that type of service. **]**

[Dental Prophylaxis

Preventive treatment which includes scaling and polishing, the complete removal of explorer-detectable calculus, soft deposits, plaque, stains and the smoothing of tooth surfaces coronal to the gingival attachment. [[For benefit purposes, periodontal maintenance shall be considered as an adult prophylaxis.]] A multiple appointment cleaning shall be considered as a single prophylaxis.

Dental Treatment Plan

The Dentist's report of recommended treatment on a form satisfactory to us which:

1. Itemizes the dental procedures and charges required for the necessary care of the mouth;
2. Lists the Usual Charges for each procedure; and
3 Is accompanied by supporting x-rays and any other appropriate diagnostic materials as required by us.

Dentist

Someone who meets both of the following requirements:

1. Is currently licensed to practice dentistry by the state in which he or she practices; and
2. Is acting within the scope of his or her license. **]**

[[Dependent

The term "Dependent":

1. Means:
   a) your lawful spouse [[or Domestic Partner]]; or
   b) your Child; but
2. Does not include a person who:[[
   a) is an Employee of your Employer unless you and your spouse [[or Domestic Partner]] are each Employees of your Employer and you have or acquire a Dependent Child. In that event, the Employee whose employment date with your Employer is the later of the two will be insured as a Dependent rather than an Employee, subject to the "Date of Eligibility" section under DEPENDENT COVERAGE and all the other terms of the policy; or
   b)]] resides outside the United States. A Dependent Child who is attending school outside the United States will be deemed to be residing within the United States. A Dependent Child residing outside the United States but not attending school will not be insured as a Dependent unless approved by us in writing.]]

[[Domestic Partner

Domestic Partner means your domestic partner as defined by your Employer and/or state law.]]

[Eligible Employee

Someone who under the terms of the policy:

1. Meets the requirements in the definition of Employee; and
2. Completes the waiting period (described in the "Date of Eligibility" section); [[and
3. Is working within the United States. An employee who is working on a temporary assignment outside the United States for a period of 12 months or less will be deemed to be working within the United States. An employee working outside the United States on other than a temporary assignment will not be considered an Eligible Employee unless approved by us in writing.]]

[[If your earnings from the Employer are reported to the Internal Revenue Service on Form 1099 or other form designated by the Internal Revenue Service to report payments to an independent contractor rather than payments to an employee, you will not be considered to be an Eligible Employee unless approved by us in writing.]]

Employee

Someone who meets the following requirements:

1. Is an employee of the Employer, as stated in PART 1: Insurance Schedule;
2. Regularly works at the Employer's usual place of business or at such place or places that the Employer's normal course of business may require;
3. Regularly works the number of hours required by the Employer to be eligible for insurance;
4. Is paid for such work in accordance with applicable Wage and Hour Laws; and
5. Is in a classification eligible for insurance as noted in the Insurance Schedule.

Employer (Eligible Employer)

The Policyholder shown on the first page.**]**

[[Full-time Student

A Child who:

1. Is attending on a full-time basis a college or university licensed as such by the state in which it is located; and
2. Is enrolled for at least the minimum number of course credits required by such college or university to maintain standing as a full-time student.]]

[[Handicapped Child

A Handicapped Child is a Child who may be insured beyond the applicable age limit shown in the definition of Child, as long as:

1. Such a Child is:
   a) unmarried;
   b) incapable of self-sustaining employment by reason of:
      i) mental retardation; or
      ii) physical handicap;
   c) dependent upon you for support and maintenance; and
   d) insured:
      i) under the policy upon attaining age 19; [[or
      ii) under the policy prior to or upon attaining age 25, if such Child is a Full-time Student;]] or
      iii) as a handicapped child under a group dental insurance plan of your Employer immediately prior to the date on which your Employer became an Eligible Employer; and]]

[[2. At the following times, you submit on the Child's behalf Proof of such incapacity and dependency:

a) initially, within 31 days of whichever of the following dates is applicable:

i) the date such Child attains age 19 if such Child is a Handicapped Child on his or her 19th birthday;

ii) [[the date between the ages of 19 and 25 on which such Child incurs an injury or contracts a sickness that results in such Child's becoming a Handicapped Child, if such Child is insured as a Full-time Student on such date;

iii) the date such Child attains age 25 if such Child is a Handicapped Child on his or her 25th birthday and was insured as a Full-time Student on the day immediately prior to attaining age 25;]] or

iv) the date on which your Employer became an Eligible Employer, if such Child is insured as a handicapped child under a group dental insurance plan of your Employer immediately prior to such date; and

b) during the 2 year period thereafter, at such other times as we may reasonably require; and

c) after 2 years, not more than once a year.]]

[Incurred (Incurred Date)

Charges for COVERED DENTAL EXPENSES will be considered incurred as follows:
Charges for multivisit procedures are considered incurred when the treatment is completed. Charges for all other services are incurred on the date that the service is provided. If This Plan includes coverage for Type IV Orthodontic Services, charges for those services are considered incurred on the date of insertion of the bands or appliance.

Late Entrant

Late Entrant means someone who:

1. Complies with the "Conditions of Insurability" for Dental Expense Benefits more than 31 days after he or she becomes eligible; or
2. Requests reinstatement of insurance which was terminated while he or she remained eligible for insurance under the policy.

Maximum Allowable Charge

The pre-determined fee (that has been agreed to [[by us or]] by an organization with whom we have contracted and the Participating Provider) charged and received for a given service by the Dentist's office in the area where the charge for such service is made.

[[Network Expenses

Covered Dental Expenses for services that are furnished by a Participating Provider.]]

[[Non-Network Expenses

Covered Dental Expenses for services that are furnished by a Non-Participating Provider.]]

Non-Participating Provider

Any Dentist who has not entered into a service agreement with [[us or with]] an organization with whom we have contracted to provide dental services at the pre-determined Maximum Allowable Charge.**]**

[[Orthodontic Treatment

Means the corrective movement of teeth through bone by means of an active appliance to correct a malocclusion.]]

[Participating Provider

Any Dentist who has entered into a service agreement with [[us or with]] an organization with whom we have contracted to provide dental services at the pre-determined Maximum Allowable Charge.

Proof

Any information that is:

1. Required by us under the terms of the policy; and
2. Satisfactory to us.

Qualified Status Change

A Qualified Status Change means:

1. Birth or adoption of a child;
2. Marriage [[or addition of a Domestic Partner]];
3. Involuntary loss of other dental coverage.

[[Retired Employee

An Eligible Employee whose employment with the Employer has ended or ends due to retirement.]]

This Plan

Your Employer’s plan of DENTAL EXPENSE BENEFITS with us as described in this Certificate and any attached Certificate Amendment(s).

Usual Charge

The fee regularly charged and received for a given service by the Dentist's office.

We (we, us, Our, our)

Sun Life Assurance Company of Canada

You (you, Your, your)

The Employee.]

PART 3: DENTAL EXPENSE BENEFITS: EMPLOYEE INSURANCE

[Date of Eligibility (Waiting Period)

You will be eligible for insurance on the date you complete the number of consecutive days or months of [[full-time]] continuous active service shown in the Insurance Schedule.

If you elect to be covered under an alternate plan of dental benefits made available by your Employer, you will not be eligible for these Dental Expense Benefits.

Conditions of Insurability

To become insured under the policy you must:

1. Satisfy the Waiting Period shown in the Insurance Schedule;
2. Complete and submit one of our enrollment forms or, if applicable, one of the enrollment forms that we and your Employer have agreed to use in place of our enrollment forms; and
3. Agree to make any required contribution toward the cost of the insurance.

[[[If you submit an enrollment form more than 31 days after the date you become an Eligible Employee or after the date of a Qualified Status Change, you cannot enroll until the next Open Enrollment Period.] [you are a Late Entrant with respect to Employee Insurance and you will be subject to the "Limitation on Late Entrants" section below.]]]

Effective Date of Insurance

Once you have met the Conditions of Insurability, you will be insured under the policy on the date you become eligible.

[If you enroll during the Open Enrollment Period, you will be insured under the policy on the date determined by your Employer.]

[[Voluntary Disenrollment

If you choose to cancel your coverage under This Plan at any time [during the Calendar Year other than during the Open Enrollment Period][during the Open Enrollment Period}, you will not be permitted to re-enroll at a later time unless you supply proof of involuntary loss of coverage under another group dental plan. The loss of coverage must be due to a valid life change event such as death, divorce or change in employment status of your spouse. If you supply such proof, you will be permitted to re-enroll [at the next Open Enrollment Period]]]

[[Benefit Waiting Period[s]

You will be insured for Type I Dental Expenses on your Effective Date of Insurance. There [is a] Benefit Waiting Period[s] for [Type II, [[and]] Type III and Type IV] Dental Expenses as indicated below. The Benefit Waiting Period(s) begin(s) on your Effective Date.

[1. The Benefit Waiting Period for Type II Dental Expenses is [6] months.]

[2. The Benefit Waiting Period for Type III Dental Expenses is [12] months.]

[3. The Benefit Waiting Period for Type IV Dental Expenses is [24] months.]

Once you have satisfied the applicable Benefit Waiting Period, your coverage for that expense type will be effective on the [first of the month coinciding with or next following the] date you have satisfied that waiting period.

[[The Benefit Waiting Period[s] shown above will not be applied if you were enrolled in the Employer's group dental plan that was in force on the day before the effective date of This Plan.]]]]

[[Limitation on Late Entrants

For the first 24 months that a Late Entrant is insured for these DENTAL EXPENSE BENEFITS, the benefits will be limited to the benefits shown in items 1 and 2 below:

1. Benefits for the first 12 months will be limited to Type I COVERED DENTAL EXPENSES.
2. Benefits for the second 12 months will be limited to Type I and Type II COVERED DENTAL EXPENSES

If you request reinstatement of insurance that was terminated while you remained eligible for such insurance under the policy, the above limitations will apply from the date on which such insurance is reinstated. Any time period for which such insurance was effective prior to such date cannot be used to satisfy the time limitations stated above.]]]

[[PART 3A: DENTAL EXPENSE BENEFITS: DEPENDENT COVERAGE

Date of Eligibility

If you have at least one Dependent on the date you become insured for Employee Insurance, you will become eligible for Dependent Coverage on that date. If you do not have a Dependent on that date, you will become eligible for Dependent Coverage on the date that you acquire one. [[If you and your spouse [[or Domestic Partner]] are both insured as Employees of your Employer on the date you acquire a Dependent Child, then on such date, the Employee whose employment date with the Employer is the later of the two will be deemed a Dependent rather than an Employee, subject to all the terms of the policy.]]

Conditions of Insurability

To become insured with respect to a Dependent:

1. You must satisfy the Waiting Period shown in the Insurance Schedule;
2. You must be insured for Employee Insurance;
3. Your Employer must notify us that you have or have acquired such Dependent;
4. You must agree in writing to make any required contribution.
5. If any of the requirements in items 3, or 4, of this section are met more than 31 days from the date:
   a) you become eligible for coverage for a Dependent;
   b) your Child reaches age 3; or
   c) of a Qualifying Status Change, then

   you cannot enroll that Dependent until the next Open Enrollment Period.

Effective Date of Insurance

Once you have met the Conditions of Insurability, you will be insured, with respect to your Dependent[[:

1.]] on the date you become eligible for Dependent Coverage.[[or

2. If you enroll your Dependent during the Open Enrollment Period, on the date determined by your Employer.]]

[[Voluntary Disenrollment

If you choose to cancel your Dependent Coverage at any time [during the Calendar Year other than during the Open Enrollment Period][during the Open Enrollment Period}, you will not be permitted to re-enroll for Dependent Coverage at a later time unless you supply proof of involuntary loss of coverage under another group dental plan. The loss of coverage must be due to a valid life change event such as death, divorce or change in employment status of your spouse. If you supply such proof, you will be permitted to re-enroll [at the next Open Enrollment Period]]]

[[Benefit Waiting Period[s]

You will be insured for Type I Dental Expenses on the Effective Date of your Dependent Coverage. There [is a] Benefit Waiting Period[s] for [Type II, [[and]] Type III and Type IV] Dental Expenses as indicated below. Benefit Waiting Period(s) begin on your Effective Date.

[1. The Benefit Waiting Period for Type II Dental Expenses is [6] months.]

[2. The Benefit Waiting Period for Type III Dental Expenses is [12] months.]

[3. The Benefit Waiting Period for Type IV Dental Expenses is [24] months.]

If you are insured for Dependent Coverage and you have satisfied the applicable Benefit Waiting Period, your Dependent Coverage for that expense type will be effective on the [first of the month coinciding with or next following the] date you have satisfied that waiting period.

[[The Benefit Waiting Period[s] shown above will not be applied if you were enrolled in the Employer's group dental plan that was in force on the day before the effective date of This Plan.]]]]

[[Limitation on Late Entrants

If you are a Late Entrant, benefits for the first 24 months of coverage for your Dependent will be limited to the benefits shown in items 1 and 2 below :

1. Benefits for the first 12 months will be limited to Type I COVERED DENTAL EXPENSES.
2. Benefits for the second 12 months will be limited to Type I and Type II COVERED DENTAL EXPENSES.**]]**

PART 4: DENTAL EXPENSE BENEFITS: DETERMINATION OF BENEFITS

[Pre-Determination of Benefits

Pre-Determination of Benefits is recommended for extensive treatment such as root canal therapy, crowns, bridges and periodontal treatment, if such services are included under This Plan. We recommend that the DENTAL TREATMENT PLAN be submitted to us for review before treatment begins. We will notify you and the Dentist of the benefits payable based upon the DENTAL TREATMENT PLAN. In determining the amount of benefits payable, consideration will be given to Alternate Dental Treatment that will, as determined by us, accomplish a professionally satisfactory result. If you and the Dentist agree to a more costly method of treatment, than that determined by us, the excess amount will not be paid by us. Pre-determination of Benefits is not required and failure to submit a Pre-Determination of Benefits does not affect the amount of benefits payable by us.

Conditions Under Which Benefits Are Payable

We will pay benefits as described below subject to the following:

1. Our payment of benefits described below is subject to all the terms and conditions of the policy;
2. We will not pay benefits for any one item of expense under more than one provision of the policy. All related dental expenses will be considered as part of the most comprehensive procedure and only the benefit for such procedure will be payable; and
3. The maximum amount that we will pay for[[:
   a)]] Type [[I,]] [[Type II and]] Type III COVERED DENTAL EXPENSES [[combined]] is described in the "Calendar Year Maximum Benefit" section below;[[and
   b) Type IV COVERED DENTAL EXPENSES is described in the "Lifetime Maximum Benefit" section below.]]

Benefits Payable with respect to Type I, [Type II] [and Type III] COVERED DENTAL EXPENSES

If during a Calendar Year a Covered Person Incurs COVERED DENTAL EXPENSES in excess of the Deductible, we will pay to you a benefit equal to the applicable percentage shown in the Insurance Schedule of Type I, [Type II] [and/or Type III] COVERED DENTAL EXPENSES Incurred in excess of the applicable Deductible, subject to the Calendar Year Maximum Benefit.]

[[Benefits Payable For Type IV COVERED DENTAL EXPENSES

Upon receipt of Proof of claim that any Covered Person has Incurred Type IV COVERED DENTAL EXPENSES, the benefit payable will be:

1. Equal to the percentage shown in the Insurance Schedule for Type IV COVERED DENTAL EXPENSES; and
2. Limited to the Lifetime Maximum Benefit.]]

[Deductible

[[Any Per Person Deductible per [[Calendar Year]] [[Lifetime]] for each type of COVERED DENTAL EXPENSE is shown in the Insurance Schedule. The amounts to be applied to meet the Deductible must be charges for COVERED DENTAL EXPENSES.

Amounts applied for your family will not exceed the Maximum Family Deductible shown in the Insurance Schedule in any Calendar Year, even if the Per Person Deductible has not been met.]]

[[The Per Person Deductible amounts for Network and Non-Network Expenses per Calendar Year for each type of COVERED DENTAL EXPENSE are shown in the Insurance Schedule. When Covered Dental Expenses are Incurred, the applicable deductible (Network or Non-Network) must be met before any benefits are payable for those expenses. Covered Dental Expenses Incurred toward the satisfaction of one of these deductibles (Network or Non-Network) in a Calendar Year will be applied toward the satisfaction of the other deductible (Network or Non-Network) for that year. The maximum Per Person Deductible for a Calendar Year will not exceed the Per Person Deductible amount for Non-Network Expenses shown in the Insurance Schedule.

Amounts applied for your family in any Calendar Year will not exceed the Maximum Family Deductibles for Network and Non-Network Expenses that are shown in the Insurance Schedule, even if the Per Person Deductible has not been met.]]

Calendar Year Maximum Benefit

[[The Per Person Maximum Benefit in each Calendar Year for [Type I, Type II and Type III] expenses [[combined]] is shown in the Insurance Schedule. The Calendar Year Maximum Benefit applies to all periods of time the Covered Person is insured during a Calendar Year regardless of any interruption in coverage for this insurance.

This Maximum Benefit applies to all COVERED DENTAL EXPENSES whether they are Network or Non-Network Expenses.]]

[[The Per Person Maximum Benefit amounts for Network and Non-Network Expenses in each Calendar Year for Type I, Type II and Type III expenses combined are shown in the Insurance Schedule.

Only Network Expenses will be applied toward the Per Person Maximum Benefit for Network Expenses. Only Non-Network Expenses will be applied toward the Per Person Maximum Benefit for Non-Network Expenses.

The Per Person Maximum Benefit for Network and Non-Network Expenses combined is shown in the Insurance Schedule.]]

The Maximum Benefit applies to all periods of time the Covered Person is insured during a Calendar Year regardless of any interruptions in coverage for this insurance. **]**

[[Lifetime Maximum Benefit

[[The Lifetime Maximum Benefit payable for any Covered Person who Incurs Type IV expenses is shown in the Insurance Schedule. The Lifetime Maximum Benefit applies to all periods of time the Covered Person is insured for DENTAL EXPENSE BENEFITS under the policy regardless of any interruptions in coverage for this insurance.]]

[[The Per Person Lifetime Maximum Benefit amounts for Network and Non-Network Type IV expenses are shown in the Insurance Schedule. Only Network Expenses will be applied toward the Per Person Lifetime Maximum Benefit for Network Expenses. Only Non-Network Expenses will be applied toward the Per Person Lifetime Maximum Benefit for Non-Network Expenses. The Per Person Lifetime Maximum Benefit for Network and Non-Network Expenses combined is shown in the Insurance Schedule. The Lifetime Maximum Benefit applies to all periods of time the Covered Person is insured for DENTAL EXPENSE BENEFITS under the policy regardless of any interruptions in coverage for this insurance.]]

This Maximum Benefit applies to all Type IV COVERED DENTAL EXPENSES whether they are Network or Non-Network Expenses.]]

[Alternate Dental Treatment

If we determine that alternate procedures, services or courses of treatment can be performed to correct a dental condition, payment will be considered for the least costly procedure which we determine will produce a professionally satisfactory result.

Favorable Result of Treatment

Benefits will be considered only for treatment that we determine has a reasonably favorable prognosis.]

[Benefits After Termination of Insurance

No benefits are available after a Covered Person's insurance ends with the exception of the following:

Benefits are available for procedures requiring multiple visits if the treatment is started while a Covered Person is insured and completed within 90 days after the Covered Person's insurance ends. Treatment is considered started when the tooth is irrevocably altered. This extension is limited to crowns, fixed bridges, inlays, onlays, full dentures, partial dentures and root canal therapy if such services are included under This Plan. A pre-determination for any Dental Treatment Plan does not constitute treatment started. If Orthodontic Treatment is included in This Plan, benefits for Type IV Expenses will be continued through the last day of the calendar month in which coverage terminates.]

PART 5: DENTAL EXPENSE BENEFITS: COVERED DENTAL EXPENSES

A COVERED DENTAL EXPENSE is:

1. With respect to services rendered by a Participating Provider, the lesser of the Usual Charge or the Maximum Allowable Charge;
2. With respect to services rendered by a Non- Participating Provider, the lesser of the Usual Charge or the Customary Charge [[or the Maximum Allowable Charge]]

for any of the dental services listed below, when those services are performed by a Dentist and are essential, as determined by us, for the necessary dental care of a Covered Person, and which have a favorable prognosis, as determined by us.

The following is a list of those dental services which will be considered as COVERED DENTAL EXPENSES; expenses that are Incurred for the performance of any dental service not listed below will be considered a COVERED DENTAL EXPENSE only if we agree in writing to accept such expenses as COVERED DENTAL EXPENSES. If we so agree, the benefit that we pay will be consistent, as determined by us, with a payment for such similar COVERED DENTAL EXPENSES that would provide the least costly professionally adequate treatment.

Type I Dental Services

Service	Special Limitations
[Oral Evaluations: Comprehensive and Periodic	Limited to 2 of these services in any 12 consecutive month period. Comprehensive evaluations are limited to one time per dental office unless there is a significant change in dental health or if the patient is absent from the office for 3 or more years
Oral Evaluations: Consultations and Limited Problem focused	Limited to 1 of these services per dentist per patient in any 12 [consecutive month] period.
Oral Evaluation: Detailed Problem focused	Limited to 1 time per dentist per eligible diagnosis in any 12 [consecutive month] period.
[[Bite-Wing X-rays	Limited to 1 set in any 12 [consecutive month] period [[for Covered Persons under age 14 and 1 set in any 24 consecutive month period for Covered Persons age 14 and older.]]]]
Dental Prophylaxis	Limited to 2 times in any 12 [consecutive month] period; 1 additional for a Covered Person under the care of a medical professional for pregnancy.
Fluoride Treatments	Limited to 2 times in any 12 [consecutive month] period and to Covered Persons under the age of 19.
Space Maintainers	Limited to 1 in any [3 year] period for Covered Persons under the age of 19 when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not develop.
Sealants	Limited to 1 time per tooth in any 36 [consecutive month] period. Limited to permanent first and second molars and to Covered Persons under age 16.
Palliative Treatment]	

[Type II Dental Services

[[You will not be eligible for Type II COVERED DENTAL EXPENSES until [the first day of the month coinciding with or next following the date] you have been insured under the policy for at least 12 consecutive months. [[This Benefit Waiting Period will not be applied if you were enrolled in the Employer's group dental plan that was in force on the day before the effective date of This Plan.]]]]

Service	Special Limitations
[Simple Extraction	
Full Mouth X-rays	Limited to 1 in any [60 consecutive month period].
[All other X-rays]	
Amalgam Restorations	Limited to 1 time per tooth surface in any 12 consecutive month period. Restorations involving multiple surfaces will be combined for benefit purposes and paid according to the number of discrete surfaces treated.
Composite Restorations	Limited to 1 time per tooth surface in any 12 consecutive month period. [Restorations on posterior teeth will be paid as an amalgam restoration].
Stainless Steel Crowns	Limited to 1 time per tooth per lifetime and to Covered Persons under age 15.
Re-cement Cast Post, Inlays, Crowns, Bridges	Considered part of the charge for the cast post, inlay, crown or bridge if the recementation is done by the same dentist and is within 12 consecutive months of the crown or bridge insertion. Subsequent recementations are limited to [one in any 12 consecutive month] period.
Repairs to Full Dentures, Partial Dentures, Bridges	
Hemisection	
Pulpal Therapy	Limited to 1 time per eligible tooth per lifetime. [Eligible teeth are primary anterior teeth for Covered Persons under age 6 and primary posterior molars for Covered Persons who are under age 12].
Root Canal Therapy	Limited to 1 time per tooth per lifetime.
Root Canal Retreatment	Limited to 1 time per tooth per lifetime.]

[Apicoectomy and Retrograde Filling	
Scaling and Root Planing	Limited to 1 time per quadrant of the mouth in any 24 [consecutive month] period.
Periodontal Maintenance following active periodontal therapy	Limited to 1 time in any 6 [consecutive month] period in addition to routine dental prophylaxis.
Surgical periodontal procedures	Once per area of the mouth in any 24 [consecutive month] period.
Guided tissue regeneration	Limited to 1 time per tooth per lifetime.
Full mouth debridement	Limited to 1 time per tooth per lifetime.
[[Biopsy]]	
Alveoplasty	
Incision and Drainage	
[[Removal of a Cyst	Not payable in addition to extraction performed in the same site on the same date.]]
Surgical Extraction of Erupted Teeth and Impacted Teeth	
General Anesthesia[,Nitrous Oxide] [IV Sedation]]	

[Type III Dental Services

[[You will not be eligible for Type III COVERED DENTAL EXPENSES until [the first day of the month coinciding with or next following the date] you have been insured under the policy for at least 12 consecutive months. [[This Benefit Waiting Period will not be applied if you were enrolled in the Employer's group dental plan that was in force on the day before the effective date of This Plan.]]]]

Service	Special Limitations
Inlays and Onlays	Covered only when the tooth cannot be restored by a filling or by other means. Limited to 1 per tooth in any 5 [Calendar Years.]
[[Porcelain Restorations	Covered only if the tooth cannot be restored by a filling or by other means.]]
Crown Buildup or Core Buildup	Limited to 1 per tooth in any 5 [Calendar Years.]
Crowns	Covered only if the tooth cannot be restored by a filling or by other means. Limited to 1 per tooth in any 5 [Calendar Years.]
Cast Post and Core	Limited to 1 per tooth in any 5 [Calendar Years].
Full or Partial Dentures	[See item 32 of EXCLUSIONS.] Limited to 1 in any 5 [Calendar Years].
Relining Dentures, Rebasing Dentures or Denture Adjustments	Considered part of the denture charges if services are provided by the same dentist and are within 6 months of insertion. Subsequent relining or rebasing is limited to 1 time in any 36 [consecutive month] period.
Fixed Bridges	[See item 32 of EXCLUSIONS.] Limited to 1 in any 5 [Calendar Years].
Root Recovery	
Frenectomy]	

[[Type IV Orthodontic Dental Services

[[You will not be eligible for Type IV COVERED DENTAL EXPENSES until [the first day of the month coinciding with or next following the date] you have been insured under the policy for at least 24 consecutive months. [[This Benefit Waiting Period will not be applied if you were enrolled in the Employer's group dental plan that was in force on the day before the effective date of This Plan.]]]]

Service	Special Limitations
Cephalometric X-ray	
Orthodontic Treatment	
Study Models]]	

PART 6: DENTAL EXPENSE BENEFITS: EXCLUSIONS

[COVERED DENTAL EXPENSES do not include and no benefits are provided for:

1. Procedures which are not included in the list of COVERED DENTAL EXPENSES.
2. Procedures which are elective. (e.g. the prophylactic extraction of third molars).
3. Procedures related to the change of vertical dimension, restoration of occlusion, bite registration, or bite analysis.
4. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
5. Implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants.
6 Specialized procedures and techniques (e.g. precision or semi-precision attachments, copings, over dentures or customized prostheses or attachments.)
7. Duplicate dentures, prosthetic devices or any other duplicative device.
8. Procedures that we determine are cosmetic in nature.
9. Charges for any of the following:
   a) dental care resulting from any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of an country or international authority;
   b) dental care resulting from any injury which is self-inflicted or not caused by an accident;
   c) dental care resulting from active participation in a riot;

      The words "participation" and "riot" in the phrase "participation in a riot" will be defined as follows:

      Participation - includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but will not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

      Riot - includes all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together whether or not acting with common intent and whether or not damage to person or property or unlawful act or acts is the intent or the consequences of such disorder; and
   d) dental care resulting from participation in the commission of a felony.
10. Dental care arising out of or in the course of employment for pay or profit or which is covered by Workers' Compensation or a similar law, or for which the Covered Person is entitled to payment under an automobile insurance policy. Benefits paid by us would be in excess to the third-party benefits and therefore, we would have the right of recovery for any benefits paid in excess.
11. Charges for pulp caps.
12. Charges for failure to keep appointments.
13. Charges for diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are temporomandibular joint disorders or other conditions of the joint linking the jaw bone and the complex muscles, nerves and other tissues related to the joint.
14. COVERED DENTAL EXPENSES Incurred while insurance is not in force under This Plan.
15. Charges for care, treatment, services, or supplies to the extent that any benefit is provided by Medicare.
16. Charges which are not customarily made when there is no insurance, or charges for which there is no legal obligation to pay.
17. Dental care which is not customarily performed or which is Experimental in nature. . By Experimental, we mean: The use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which we determine is not acceptable standard dental treatment of the condition being treated. Any such items requiring federal or other governmental agency approval which was not granted at the time the services were rendered will also be considered Experimental. In making the determination as to whether dental care is Experimental, we will rely on the advice of the general dental community including, but not limited to dental consultants and dental journals and/or regulations.]

[18. Charges for oral hygiene instruction, a plaque control program, tobacco counseling or dietary instruction.

19. Charges for treatment started prior to a Covered Person's Effective Date. Multivisit procedures are considered started when the teeth are irrevocably altered. For example, crowns, bridges and dentures are considered started when the teeth are prepared and impressions are taken. Root canals are considered started when the tooth is open and pulp is removed.

20. Charges for house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).

21. Charges for diagnostic casts.

22. Charges for periodontal splinting of teeth by any method.

23. Charges for prescription and non-prescription drugs, vitamins or dietary supplements.

24. Charges for treatment of fractures and dislocations of the jaw.

25. Charges for treatment of malignancies or neoplasms.

26. Charges for preventive restorations.

27. Charges for any treatment of congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone or required as the result of orthognathic surgery including orthodontic treatment).

28. Charges for treatment of and appliances for bruxism (night grinding of teeth).

29. Charges for incomplete treatment (e.g. patient does not return to complete treatment) and charges for temporary services (e.g. temporary restorations.

30. Charges for procedures that are:

    a) part of a service but are reported as separate services;

    b) reported in a treatment sequence that is not appropriate;

    c) misreported or that represent a procedure other than the one reported.

31. [[Orthodontic Treatment]] [[for Covered Persons age 19 and older.]]

[[32. The initial placement of prosthetics (e.g. full or partial dentures or fixed bridges) if the prosthetic replaces one or more teeth missing prior to the Covered Person's effective date of coverage, including congenitally missing teeth.]] [[This exclusion will not be applied if you were enrolled in the Employer's group dental plan that was in force on the day before the effective date of This Plan]].

[[33. Charges for the administration of [nitrous oxide and/or] IV sedation.]]

[[34. Charges for treatment that is not dentally necessary or not deemed to be within generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the determination will be made by us.]]]

PART 8: TERMINATION PROVISIONS

[Termination of Employee [[and Dependent]] Insurance

The DENTAL EXPENSE BENEFITS coverage for you [[and your Dependents]] will automatically cease on the earliest date shown below:

[[1. On the date you are no longer Actively At Work except that:

a) while you are sick or injured, your employment will be deemed to continue, for up to 12 months from the date your disability began as long as your Employer keeps paying premiums on your behalf;

b) while you are temporarily laid off or on a temporary leave of absence, your employment will be deemed to continue, as long as premium payments are made, for up to two months, unless your Employer cancels your insurance before the end of that time;

c) while you are on an approved leave of absence granted in accordance with a State Family Leave Law or the Federal Family and Medical Leave Act (FMLA), your coverage will be deemed to continue, provided premium payments are made and the continuation of coverage during this leave is based upon a uniform policy of your Employer and not individual selection, for the lesser of the duration of the approved leave or 4 months from the last day you are Actively At Work, unless your Employer cancels your insurance before the end of that time;

d) while you are on a leave of absence due to your military service in any of the Uniformed Services of the United States, your employment will be deemed to continue as outlined in either item 1-b or 1-c above, as applicable, as long as premium payments are made, unless your Employer cancels your insurance before the end of that time. For additional information on how you can continue your coverage, see the **Uniformed Services Employment and Re-employment Rights Act of 1994** part.

[[e) when you become a Retired Employee, your Dental Expense Benefits coverage will be deemed to continue as long as your Employer keeps paying premiums on your behalf;]]]]

2. On the date which you cease to be in a class of Employees who are eligible for such coverage. This means you are no longer an active [[full-time]] Employee;
3. On the date you fail to make any required contribution;
4. On the date such coverage is terminated for any reason;
5. On the date such coverage is terminated for the class of Employees to which you belong;

[[6. On the date the policy terminates.]]

[[6. On the date your Employer's participation in the Trust and under the policy is terminated.]]

7. On the date you become covered under an alternate plan of dental benefits made available by your Employer.

[[Termination of Dependent Coverage Only

The DENTAL EXPENSE BENEFITS coverage for your Dependents only will automatically cease before your Employee Insurance on the earliest of:

1. The date you cease to be in a class of Employees who are eligible for such Dependent Coverage;
2. The date you fail to make any required contribution for such Dependent Coverage;
3. The date such Dependent Coverage is terminated for any reason; or
4. The date a person ceases to be a Dependent as defined in the policy, but only with respect to such person.**]]**

Continuation Coverage

Federal law requires certain employers to offer continuation coverage to Employees for a specified period of time upon termination of employment or reduction of work hours for any reason other than gross misconduct. You should contact your Employer to find out whether or not this requirement applies to you and your Employer. Your employer will advise you of your rights to continuation coverage, if any, and the cost. If this requirement does apply, you must elect to continue coverage within 60 days from your qualifying event or notification of rights by your Employer, whichever is later. [[You may elect to extend coverage for your eligible Dependent(s), or your eligible Dependent(s) may elect to continue coverage under certain circumstances or qualifying events. Dependent(s) must elect to continue coverage with 60 days from the event or notification of rights by your Employer, whichever is later.]] You must pay the required premium for continuation coverage directly to your Employer. We are not responsible for determining who is eligible for continuation coverage. If This Plan contains a continuance provision that is mandated by a state law, Covered Persons eligible under that provision will have the choice of electing: 1) the state continuance coverage and subsequently the federal continuance coverage, if allowed by state law; or 2) the federal continuance alone. **]**

PART 10: GENERAL DENTAL PROVISIONS

[Proofs of Claim

Proof of claim must be sent to us in writing within 90 days of the Incurred Date of the dental treatment. If such Proof cannot be sent within this time limit, it must be sent as soon as reasonably possible, but not later than 12 months of the Incurred Date.

Such Proofs of claim must be made on the forms we require. If such forms are not available due to our failure to furnish them upon request of the Policyholder [[or Employer]], your compliance with the remaining terms of this section will satisfy your responsibility to us regarding Proofs of claim.

You [[and all persons covered under the policy]] are required to furnish any information that we may reasonably require to review your Proof of claim. If you [[or other Covered Persons]] fail to furnish information we require to verify the eligibility or insurability of you [[or other Covered Persons]], we reserve the right to terminate or rescind such coverage. Also, we have the right to require any of the following:

1. A complete dental chart showing:
   a) extractions;
   b) missing teeth;
   c) fillings;
   d) prostheses;
   e) periodontal pocket depths; and
   f) the date of any work previously performed.
2. An itemized bill for all dental care.
3. The following exhibits:
   a) x-rays;
   b) study models;
   c) laboratory and/or hospital records.
4. A dental examination at our expense by a Dentist whom we choose.

[[5. Completion of a brief questionnaire which will specify:
   a) the degree of overjet, overbite, crowding, open bite;
   b) if teeth are impacted in crossbite, or congenitally missing;
   c) the length of treatment; and
   d) the total charge for the treatment.]]

6. Any additional information we may need to process your claim. If you [[or other covered persons]] fail to furnish information we require to verify [the eligibility of you] [[or other covered persons]], we reserve the right to terminate or rescind such coverage.

If you [[or any other covered person]] commits an act of fraud in attempting to secure benefits from us, we may terminate or rescind your [[(and your Dependents)]] coverage [[or the coverage of the person who commits such act]].

If we rescind coverage, we will refund any premium paid less any claim reimbursements.

Legal Actions

For 60 days after written Proof of claim, as required by us, has been filed, no legal or equitable action may be brought against us for that claim. No action at all may be brought against us after 3 years from the date on which written Proof of claim is required.]

[Workers' Compensation

This insurance does not take the place of or affect any requirement for coverage by Workers' Compensation Insurance.

Non-Discrimination

In the administration of This Plan, the Policyholder [[and the Employer]] are obligated to treat you and other [Employees] in like situations fairly.

Time Periods

All time periods referred to in the policy will begin and end at 12:01 A.M. standard time at the [Employer's] home office.]

Disclosure of Information
Group Dental Plan

The following document provides you with information regarding your Group Dental Benefits. This document is intended to clarify and to provide additional information about your plan. Your Group Certificate provides detailed provisions of coverage including any limitations or restrictions that apply. **You should read your certificate carefully.**

[[Dental Network

Our group dental insurance program utilizes a nationwide network of dentists. [United Concordia] is the dental network administrator used by us and is responsible for the development and management of our participating provider networks. [United Concordia] strives to provide the most comprehensive network of dentists possible in all areas across the country. All providers have the right to participate in the network provided all enrollment criteria is met and they are willing to meet the terms and conditions for participation. Key features of this plan include:

- You may receive services from a provider of your choice
- You may receive a higher level of benefits for dental services when choosing a participating provider

Provider Directories

You may obtain provider directories by contacting us at [800-451-2513] or you may view the list of participating providers on our web site at [http://ebg.sunlife.com.] It is possible that a provider may have left or joined the network since the printing of the directory. You may contact us in order to verify that a provider is a participant.

Provider Contracts

PPO provider contracts do not include "gag" clauses. Contracts do not prohibit the provider from discussing available treatment options and services or from disclosing the compensation methodology to covered persons.]]

Financial Arrangements

Reimbursements are based on various factors. Payment may be based on the Maximum Allowable Charge, Usual Charge or the Customary Charge by a participating provider. The provider is not given an incentive or bonus that encourages withholding service or influences referrals to specialists. If you would like additional information about how providers are compensated, please contact us at the telephone number listed on your ID card.

Covered Expenses

Pre-Determination of Benefits

Pre-Determination of Benefits is recommended for extensive treatment such as root canal therapy, crowns, bridges and periodontal treatment, if such services are included under This Plan. We recommend that the DENTAL TREATMENT PLAN be submitted to us for review before treatment begins. We will notify you and the Dentist of the benefits payable based upon the DENTAL TREATMENT PLAN. In determining the amount of benefits payable, consideration will be given to Alternate Dental Treatment that will, as determined by us, accomplish a professionally satisfactory result. If you and the Dentist agree to a more costly method of treatment, than that determined by us, the excess amount will not be paid by us. Pre-determination of Benefits is not required and failure to submit a Pre-Determination of Benefits does not affect the amount of benefits payable by us.

Pre-Determination of Benefits is not a guarantee of benefits under your dental plan. You or your dependent must meet the plan's eligibility requirements and services must be covered expenses for benefits to be payable. Please be sure to read your certificate carefully to ensure coverage is provided under your plan.

Retrospective Review

Certain claims are subject to retrospective review to determine whether the supplies or services provided are essential as required by your plan. Other than expenses for which coverage is required by state law, expenses for treatment or supplies that are not essential are not covered by your plan.

Description of Benefits

The *Insurance Schedule* and *Dental Expense Benefits: Covered Expenses* parts of your Group Certificate contain information regarding benefits including benefit maximums and limitations. The *Insurance Schedule* part outlines the benefit levels for treatment including information about your responsibility for payment related to coinsurance, co-payments, deductibles and annual limits. If services are not covered by the plan, you are responsible for payment.

The *Dental Expense Benefits: Exclusions* part of your Group Certificate contains information about charges for which no benefits are paid. Benefits are payable for essential treatment, subject to all of the provisions of your Group Certificate.

Confidentiality of Patient Information

Dental records and other patient information will be released only upon written authorization from the insured. Such information may only be used to determine eligibility and benefits payable under the plan. All employees take appropriate measures to safeguard the security and confidentiality of patient information.

[[Rights and Responsibilities

We are committed to treating all our enrollees in a manner that respects their rights under this contract. We expect the providers of care to treat our enrollees as they would any other patient in terms of care provided, accommodations, and timeliness of access to care. We do not solicit enrollee satisfaction information.]]

Grievance Process:

If you disagree with a claim decision made by us, within 180 calendar days of receipt of such claim decision, you, your dentist, or your representative may call us at the toll-free telephone number listed on your ID card to initiate an appeal.